STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155505	B. WING	G		10/18/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
ROBIN F	RUN HEALTH CEN	TER			OBIN RUN W IAPOLIS, IN 46268		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000	This visit was	for a Recertification and	F00	00	I have analoged the Dian of		
			100	00	I have enclosed the Plan of Correction for the		
	State Licensu	re Survey.			above-referenced facility in		
	Cumiou dotoo	October 15, 16, 17			response to the Statement of		
	1	October 15, 16, 17,			Deficiencies. While this		
	and 18, 2012				document is being submitted a	as	
	Equility number	or: 001156			confirmation of the facility's on-going efforts to comply with	n all	
	Facility number				statutory and regulatory		
					requirements, it should not be		
	AIM number:	100453350			construed as an admission or		
	0				agreement with the findings ar		
	Survey team:	D. WT			conclusions in the Statement of Deficiencies. In this documen		
	Janet Stanton	, R.NTeam			we have outlined specific action		
	Coordinator				in response to identified issue		
	Michelle Hoste	·			We have not provided a detail	ed	
	Michelle Carte	•			response to each allegation or		
	Heather Lay, I	R.N. (10/15, 16, 17)			findings, nor have we identified mitigating factors.	d	
	Communication of the				magaang laotoro.		
	Census bed ty	/pe:			This provider respectfully		
	SNF12				requests that this 2567 Plan o	f	
	SNF/NF62				Correction be considered the	r.	
	Total74				Letter of Credible Allegation of Compliance and requests a Po		
	Company	· to one a c			Survey Review on or after		
	Census payor	type:			November 17, 2012.		
	Medicare10						
	Medicaid44						
	Other20						
	Total74						
	Community 45						
	Sample: 15						
	Supplemental sample: 2						
	These deficier	ncies reflect state					
		in accordance with 410					
	mangs cited	in accordance with 410					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

001156

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE CO A. BUILDING B. WING	00			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	REGULATORY OF IAC 16.2.			(EACH CORRECTIVE ACTION	SHOULD BE		

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Event ID: NQP211

Facility ID: 001156

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155505	B. WIN	IG		10/18/	2012
NAME OF D	PROVIDER OR SUPPLIEI		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF I	KOVIDEK OK 301 I EIEI				OBIN RUN W		
ROBIN R	UN HEALTH CEN	ΓER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0156 SS=B	483.10(b)(5) - (10) NOTICE OF RIG CHARGES The facility must orally and in writi resident understa all rules and regu conduct and resp in the facility. Th the resident with State developed Act. Such notific or upon admissic stay. Receipt of amendments to i writing. The facility must entitled to Medica the time of admis or, when the resi Medicaid of the it included in nursii State plan and fo not be charged; t services that the the resident may amount of charge	inform the resident both ng in a language that the ands of his or her rights and alations governing resident bonsibilities during the stay e facility must also provide the notice (if any) of the under §1919(e)(6) of the ation must be made prior to on and during the resident's such information, and any t, must be acknowledged in inform each resident who is aid benefits, in writing, at assion to the nursing facility dent becomes eligible for tems and services that are ng facility services under the or which the resident may chose other items and facility offers and for which be charged, and the es for those services; and		TAG	DEPICIENCY)		DATE
		dent when changes are s and services specified in					
	paragraphs (5)(i)	(A) and (B) of this section.					
	before, or at the periodically durin services available charges for those charges for servi	inform each resident time of admission, and g the resident's stay, of e in the facility and of e services, including any ces not covered under ne facility's per diem rate.					
	The facility must of legal rights wh	furnish a written description ich includes:					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155505	B. WIN			10/18/	2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R			OBIN RUN W		
DODIN D		TED.					
ROBINK	UN HEALTH CENT	IER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
	A description of t	he manner of protecting					
	•	inder paragraph (c) of this					
	section;	,					
	A description of t	he requirements and					
	procedures for es	stablishing eligibility for					
	Medicaid, includir	ng the right to request an					
		er section 1924(c) which					
		xtent of a couple's					
	•	urces at the time of					
		n and attributes to the					
	•	se an equitable share of					
		cannot be considered					
		ment toward the cost of the					
		pouse's medical care in his					
	•	spending down to					
	Medicaid eligibilit	y levels.					
	A						
		es, addresses, and					
	•	ers of all pertinent State					
		roups such as the State cation agency, the State					
	-	he State ombudsman					
		tection and advocacy					
	. •	Medicaid fraud control unit;					
		that the resident may file a					
		e State survey and					
	•	cy concerning resident					
	•	ind misappropriation of					
		in the facility, and					
		with the advance directives					
	requirements.	 					
	•						
	The facility must	comply with the					
	•	ecified in subpart I of part					
		er related to maintaining					
		nd procedures regarding					
	advance directive	es. These requirements					
	include provisions	s to inform and provide					
	written informatio	n to all adult residents					
		ght to accept or refuse					
	medical or surgic	al treatment and, at the					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155505	B. WING			10/18/	2012
			D. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			OBIN RUN W		
ROBIN R	UN HEALTH CENT	TFR .		INDIANAPOLIS, IN 46268			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		n, formulate an advance		IAU			DATE
		cludes a written description					
		licies to implement					
	advance directives and applicable State law.						
	The facility must inform each resident of the						
		and way of contacting the					
	physician respon	sible for his or her care.					
	The facility must	prominently display in the					
		ormation, and provide to					
	residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,						
		ve refunds for previous					
		d by such benefits.	F01	5 (11/17/2012
		ervation and interview,	F01:	56	F156 Notice of Rights, Rules		11/17/2012
		d to ensure information			Services, and Charges It is the practice of the provider to ensure		
		icare, Medicaid, and			that alleged violations involvin		
	_	ocacy agencies was			the notice of rights, rules,	9	
	readily accessi	ble to the residents of			services, and charges are in		
	a locked deme	ntia unit. This deficient			accordance with State and		
	practice affecte	ed 22 of 74 residents			Federal Law. What corrective		
	who resided or	n the locked dementia			action(s) will be accomplished	∌d	
	unit.				for those residents found to		
					have been affected by the		
	Findings includ	le:			deficient practice: The community notified residents a	and	
					their responsible parties on thi		
	On 10/16/12 at	t 9:15 A.M.			unit regarding Medicare,	-	
		as made in the locked			Medicaid, and contacting		
		Information regarding			advocacy agencies. This		
		licaid, and how to			information is now readily		
					accessible to the residents on		
		acy agencies was not			secured Clare Bridge Dement Unit. How other residents	а	
	located.				having the potential to be		
					affected by the same deficien	nt	
		t 9:20 A.M., in an			practice will be identified and		
	•	Memory Care Facilitator			what corrective action(s) will		
	I indicated the a	hove information was			l ''		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	(X2) MI A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE S COMPL: 10/18/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	addition, the M indicated family to the information residents are elected unit, the to the information on 10/16/12 at interview, the Elected the factoric desired indicated the factoric desired indicated factoric desired factoric desi	ealth care center. In emory Care Facilitator y who visit have access on; however, unless scorted out of the ey do not have access on. 2:00 P.M., in an executive Director acility would post the ion in the locked			be taken: The community notified residents and their responsible parties on this unit regarding Medicare, Medicaid and contacting advocacy agencies. This information is readily accessible to the resid on the secured Clare Bridge Dementia Unit. What measures will be put into plaor what systemic changes who be made to ensure that the deficient practice does not recur: Medicare, Medicaid, a contacting advocacy agencies information was posted in plaisight of the residents on the secured Clare Bridge Dement Unit. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place: Medicare, Medicar	now ents ice ill id id, id, icy dit e		

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Event ID: NQP211

Facility ID: 001156

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155505	B. WING		10/18/2012
	PROVIDER OR SUPPLIE		6370 F	ADDRESS, CITY, STATE, ZIP CODE ROBIN RUN W NAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	483.10(b)(11) NOTIFY OF CHA (INJURY/DECLI A facility must in resident; consult physician; and if legal representa member when the the resident which the potential for intervention; a si resident's physicistatus (i.e., a defor psychosocial threatening concomplications); a significantly (i.e. existing form of the consequences, of treatment); or discharge the respecified in §483. The facility must resident and, if k representative of when there is a commate assign §483.15(e)(2); of under Federal of specified in para. The facility must update the addressident's leginterested family	ANGES NE/ROOM, ETC) Inmediately inform the with the resident's known, notify the resident's tive or an interested family here is an accident involving the results in injury and has requiring physician gnificant change in the hal, mental, or psychosocial herioration in health, mental, herioration in health, mental, herioration in health, mental, herioration in health in a need to discontinue an hereatment due to adverse her to commence a new form ha decision to transfer or hisident from the facility as 13.12(a). Also promptly notify the hnown, the resident's legal her interested family member hange in room or hment as specified in har a change in resident rights hereal state law or regulations as hereal graph (b)(1) of this section. Hereord and periodically hereal representative or hereal representative or hereal residents her			
	physicians we change in con	ord review and facility failed to ensure re notified regarding a dition for Residents #40. The deficiency	F0157	F157 Notify of Changes It is the practice of this provide ensure that the Notification of Changes, (Injury/Decline/Rooi is in accordance with State and	m)

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLI	ETED
		155505	B. WIN			10/18/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	ę.		6370 R	OBIN RUN W		
ROBIN R	RUN HEALTH CENT	ΓER		INDIAN	IAPOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG		od	DATE
		residents reviewed for			Federal law through established procedures.	5u	
	l · •	ication in a sample of			procedures:		
	15.						
	l <u>_</u>				What corrective action(s) wil	ı	
	Findings includ	le:			be accomplished for those		
					residents found to have been	1	
		record for Resident			affected by the deficient practice:		
		ved on 10/16/12 at			ριασιίσε.		
	12:45 P.M.				Resident #30 physician was		
					notified on 9/11/12 and family		
	Diagnoses for Resident #30 included, but were not limited to, thrombocytopenia, high blood				was notified on 9/28/12. Resi		
					#30 has edema per Physician		
					and is being treated with Furosemide.		
	pressure, insor	mnia, macular			i dioscinide.		
	degeneration,	dysphagia, and muscle			Resident #40 physician and		
	weakness.				family were notified on 9/27/12		
					and order for Cipro was initiate		
	Nursing notes,	dated 9/01/12 at 11:00			No further signs of infection fo this resident.	r	
	A.M., indicated	I, "Resident's bilat			this resident.		
	(bilateral) eder	na has gotten worse,			Resident #26 physician and		
	laid her down i	n bed to elevate her			family were notified on 9/13/20)12	
	legsalso c/o	(complains of) pain in			and resident was sent to the		
	•	s are very tight. + (plus			Hospital. No further signs or		
	•	emawill continue to			symptoms of unresponsivenes for this resident.	3S	
	monitor her leg				ioi tilis residerit.		
		,-					
	A document tit	led "Weekly Skin			How other residents having		
		w," with an entry dated			potential to be affected by th		
		ted "edema bilat			same deficient practice will be		
	(bilateral) legs.				identified and what correctiv	е	
	(Shaterar) legs.				action(s) will be taken:		
	On 9/28/12 at 11:00 A.M., nursing						
	notes indicated, "Left foot, 2nd			Licensed Nurses will be educa			
	(second) toe very redtender- +				on assessment, notification of		
	l	ema whole foot, +3 to			physician and family, and		
	l (biga sigil) ede	יוום אווטוכ וטטנ, יט נט			documentation of changes in		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		155505	A. BUII B. WIN			10/18/	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			OBIN RUN W		
ROBIN R	RUN HEALTH CENT	TER .			IAPOLIS, IN 46268		
			1		1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU		*		TAG	condition as well as use of the	`	DATE
		ll to Dr. (physician			clinical status change log by the		
	name) - Keflex	order."			Director of Nursing or designe		
					In addition Licensed Nurses w		
	Nursing notes,	dated 9/28/12 at 9:40			be educated on care of		
	P.M., indicated	I, "Res (resident) is on			gastrostomy tubes.		
	ATB (antibiotic) for cellulitis at left foot					
	2nd (second) to	oe"			140		
	,				What measures will be put in	nto	
	At the daily cor	nference, on 10/16/12,			place or what systemic		
	-	discussed with the			changes will be made to ensure that the deficient		
	Administrator, Director of Nursing,				practice does not recur:		
	= -	s of the exit, on			practice does not recur.		
		,			The Director of Nursing or		
		formation related to			designee will audit the clinical		
		nysician related to the			status change log daily to ens	ure	
		entation of Resident			proper change of condition		
	#30's increase	d bilateral edema to			notification occurs for physicia	ın	
	the lower extre	mities was presented.			and family.		
	2. The clinica	I record for Resident			How the corrective action(s)		
	#40 was review	ved on 10/15/12 at			will be monitored to ensure		
	1:00 P.M.				deficient practice will not red	cur,	
					i.e., what quality assurance		
	Diagnoses for	Resident #40 included,			program will be put into plac	e:	
	1	mited to, osteoporosis,					
		eration, high blood			All Clinical status -1	lbo	
	_	I fibrillation, chronic			All Clinical status changes wil reviewed weekly at the Quality		
	•				Care Meeting by the	y Oi	
	· ·	ysphagia, history of			Interdisciplinary Team. The		
		lar accident with			status of compliance with the		
		ic anxiety, left sided			clinical status change logs wil		
	pleural effusion, gastroesophageal				reviewed in the monthly Quali	ty	
	reflux disorder, failure to thrive and				Assurance Performance		
	S/P (status post) gastrostomy.			Improvement meeting.			
					Deficiency in this practice wi result in disciplinary action up		
	Nursing notes	on 9/07/12 indicated,			and including termination of the		
	_	G-tube (gastrostomy			responsible employee		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì		INSTRUCTION 00	(X3) DATE S COMPLE		
		155505	A. BUII B. WIN	LDING IG		10/18/2	
	PROVIDER OR SUPPLIER		р. W.I.V	STREET A	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	changed has lo of greenish slin	(dressing) when g. (large) amt. (amount) nmy (sic) odorous l. Passed on to day					
	10/16/12 at 1:0 "The communic night shift nurse nurse, on 9/07/day shift nurse was not aware around Reside (gastrostomy to RN #1 indicate communication	view with RN #1, on 15 P.M., she stated cation between the e and the day shift (12, was not clear. The told her (RN #1) he of a possible infection int #40's G-tube (ube) site, on 9/07/12." d there was a lack in a between the nurses the physician not of a change in					
	indicated an ar Cipro 250 mg. tablet and sprir site, daily for 7	•					
	notes further in (resident) is on	9:45 A.M., nursing dicated, "Res. ATB (antibiotic) for GI al) site infection"					
	"Clinical Status	, dated 4/1/2011, titled Change", provided by on 10/18/12 at 9:00					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE COMPL		
THIE TEAM	or condition	155505		LDING		10/18/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	10/10/	
NAME OF F	PROVIDER OR SUPPLIER	R			OBIN RUN W		
ROBIN R	UN HEALTH CENT	ΓER			APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION DATE
TAG		, but was not limited to,		TAG	BEFFEERET		DATE
	the following:	, but was not illilited to,					
	the following.						
	Policy Overvie	w; "When a resident is					
	_	aving a clinical status					
		ensed nurse will follow					
	_	umenting notification to					
		ible party, the physician					
	and other licen	sed nurses in order to					
	facilitate the ap	propriate plan of care."					
		Significant clinical					
	_	s may include, but are					
		were mental status					
	changes, comp						
	•	n, change in skin					
		r and/or integrity, new					
		and infection/antibiotic					
	therapy/isolation						
		ecord review for Resident					
	_	ted on 10/16/12 at 1 P.M.					
	to, end-stage der	ded, but were not limited					
	, ,						
	aphasia/dysphag	ıa.					
	The nurses not	tes indicated that on					
		room secondary to					
		opetite -responsive to					
		d pupils-not following					
	•	n-reflexive-somelent					
	(sic)-no change	e while in Dining					
	Room-just stop	pped eating-food feel					
		ormally eats 100%"					
		ndication in the nurses					
	notes the phys	ician was notified.					

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Event ID: NQP211

Facility ID: 001156

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		A. BUILDING B. WING	00	COMPLETED 10/18/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	conference on #13 indicated t	during the daily 10/18/12 at 1 P.M., RN hey could not find any regarding physician						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NQP211

Facility ID: 001156

If continuation sheet Page 12 of 111

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155505	B. WIN	G		10/18/	2012
	PROVIDER OR SUPPLIER			6370 R	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0167 SS=B	483.10(g)(1) RIGHT TO SURV ACCESSIBLE A resident has the results of the most facility conducted surveyors and an effect with respect to the facility must of the facility must of the facility faile post a notice of the facility faile results were residents of a limit to the facility faile results were residents of a limit observation was demential unit to thave the facility readily accessinave a sign post could be found. On 10/16/12 at interview, the facility readily accessinave a sign post could be found.	regit to examine the st recent survey of the by Federal or State y plan of correction in to the facility. make the results available and must post in a place to residents and must neir availability. ervation and interview, and to ensure survey adily accessible to the ocked dementia unit. For actice affected 22 of the resided on the ia unit. The second on the ia unit. The second of the locked hat the unit failed to y's survey results ble to the residents or sted where the results	F01		F167 Right to Survey Results Readily Accessible It is the practice of this provide ensure a resident has the right examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect the facility. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The community notified reside and their responsible parties of this unit notifying them that the most recent survey of the facilities conducted by Federal or St. surveyors will be readily accessible to residents and visitors on the secured Clare	er to to st to ents on exity	11/17/2012
		emory Care Facilitator y who visit have access			Bridge Dementia Unit.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NQP211

Facility ID: 001156

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	00	COMPL	
		155505	B. WING			10/18/	2012
	PROVIDER OR SUPPLIE		6	370 RC	DDRESS, CITY, STATE, ZIP CODE DBIN RUN W APOLIS, IN 46268		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	I	ID	The complete of the complete o		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PRI	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	Т	AG	DEFICIENCY)	16	DATE
	residents are	results; however, unless escorted out of the ey do not have access results.			How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	e ne	
					The community notified reside and their responsible parties of this unit notifying them that the most recent survey of the facilias conducted by Federal or St surveyors will be readily accessible to residents and visitors on the secured Clare Bridge Dementia Unit.	n e ity	
					What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: A survey book was prepared	to	
					which includes results of surve conducted by Federal or State surveyors. This survey book w be located at the nurse's static in the secured Clare Bridge Dementia Unit.	rill	
					How the corrective action(s) will be monitored to ensure t deficient practice will not rec i.e., what quality assurance program will be put into place	ur,	

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Event ID: NQP211

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505			(X2) MULTIPLE CO A. BUILDING B. WING	10/18	OMPLETED 0/18/2012			
	OVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON DBE DPRIATE	(X5) COMPLETION DATE		
				A survey book Quality Ass Performance Improvement tool was developed and with completed once weekly time weeks, then bi-weekly time weeks, and then quarterly thereafter until the alleged deficient practice does not Results of the Quality Assi Performance Improvement will be communicated to the Quality Assurance Perform Improvement Team.	t audit II be nes 4 es 4 recur. urance t audits ne			
IAU	REGULATORY OF	A LOC IDENTIF LING INFORMATION)	IAU	A survey book Quality Ass Performance Improvement tool was developed and with completed once weekly time weeks, then bi-weekly time weeks, and then quarterly thereafter until the alleged deficient practice does not Results of the Quality Assi Performance Improvement will be communicated to the Quality Assurance Perform	urance t audit II be nes 4 es 4 recur. urance t audits ne			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NQP211

Facility ID: 001156

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155505	B. WING			10/18/	2012
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OBIN RUN W		
ROBIN R	UN HEALTH CENT	ER			APOLIS, IN 46268		
(VA) ID	CID O (A DV C	FATEMENT OF DEPLOYENCIES		ID I	,		(2/5)
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
F0223	483.13(b), 483.13	· · · · · · · · · · · · · · · · · · ·		1110			5.112
SS=D		USE/INVOLUNTARY					
00 B	SECLUSION						
	The resident has	the right to be free from					
	verbal, sexual, ph	ysical, and mental abuse,					
		ent, and involuntary					
	seclusion.						
	The facility must r	not use verbal, mental,					
		al abuse, corporal					
		voluntary seclusion.					
	Based on recor	-	F0223	3	F223 Free From		11/17/2012
		acility failed to ensure			Abuse/Involuntary Seclusion		
		free from abuse by			-		
		nis deficient practice					
	•	residents [Residents			It is the practice of this provide	r to	
	#101 and 102]	=			ensure that alleged violations		
	_				involving Free from Abuse/Involuntary Seclusion a	ro	
	_	buse in a sample of 15			in accordance with State and	16	
	residents review				Federal law.		
	• •	esidents reviewed for					
	allegations of a				What corrective action(s) will		
		sample of 2 residents			be accomplished for those		
	reviewed. [Res	ident #100]			residents found to have been	l	
					affected by the deficient		
	Findings includ	e:			practice:		
	1. On 10/16/12	2 at 10:15 A.M.,			Resident #100, #101, and #10	2	
	Resident #102'	s record was reviewed.			have been discharged from the		
	Diagnoses incl	uded, but were not			community.		
	_	etes mellitus type II,					
		and acute renal failure.					
	, p =				How other residents having t		
	Resident #102	was discharged from			potential to be affected by the		
	the facility on 1	~			same deficient practice will be identified and what corrective		
	ine racility On I	UI 121 12.			action(s) will be taken:	•	
	Λ n " Λ d no i o o i o o	Evaluation Detail			action, in so taken		
		Evaluation Data"					
	nursing assess	ment, dated 8/9/12,					

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Event ID: NQP211

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		155505				10/18/2012
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE	
5051115					OBIN RUN W	
KORIN K	RUN HEALTH CENT	IER		INDIAN	APOLIS, IN 46268	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	indicated Resid	dent #102 was alert to			Staff will be re-educated	
	self.				regarding abuse and ensuring	
	3011.				that residents are free from	
	A 110				abuse.	
	A "Social Service Progress Note"					
	dated 8/16/12,	included, but was not			The Director of Nursing and th	
	limited to, "Res	sident is alert and			Executive Director will educate	
	oriented to per	son. Resident requires			staff on the appropriate	
	l	n ADL's [activities of			procedures of abuse	
		She is able to respond			investigations, including report	_
	, ,	unication pleasant			allegations of abuse immediate The community will continue to	
					suspend associates whom have	
	and cooperativ	e with care"			had an allegation of abuse ma	
					against them, and will continue	
	On 10/16/12 at	t 2:30 A.M., the			thoroughly investigate and	
	Executive Dire	ctor provided the			document their investigations	of
	facility investio	ation for an allegation			allegations of abuse.	
	, , ,	17/12 at 7:20 A.M.				
	01 45456 011 07	17712 at 7.20 7 t.W.				
	The chuse in "	actication included but			What measures will be put in	to
		estigation included, but			place or what systemic	
	was not limited	I to, the following:			changes will be made to	
					ensure that the deficient	
	"Indiana State	Department of Health:			practice does not recur:	
	Incident Repor	t Form: Incident Date:				
) A.M Resident's			Arrahana Oustii A	
		ent #102] Staff			An abuse Quality Assurance	_1:t
	l •	tified Nursing Assistant]			Performance Improvement au	uit
		<u> </u>			tool will be completed once weekly times 4 weeks, then	
		f Description of			bi-weekly times 4 weeks, then	
		CNA [#4] was observed			quarterly until the alleged	
	, ,	nurse [Licensed			deficient practice does not rec	ur.
	Practical Nurse	e #6] standing looking				
	at the resident	with her arms folded				
	saving 'I'm disa	appointed in you. I			How the corrective action(s)	
		ou did this.' The			will be monitored to ensure t	he
		ist had a bowel			deficient practice will not rec	ur,
	· · · · · · · · · · · · · · · · · · ·				i.e., what quality assurance	
	movement. Th				program will be put into plac	e:
	incontinent Ir	mmediate Action: The				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155505	B. WIN			10/18/	2012
NAME OF F	DDOMDED OF GUIDNI 150			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIER			6370 R	OBIN RUN W		
	RUN HEALTH CENT			<u> </u>	APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		removed from the			The abuse Quality Assurance		
		tive Measures Taken:			Performance Improvement au		
		advised by the charge			tool will be reviewed in the		
		that we do not talk to			monthly Quality Assurance		
	residents in a s	scolding manner"			Performance Improvement		
					meeting by the Quality Assura	ince	
		tive, dated 8/17/12 at			Committee.		
	· ·	uded, but was not			Deficiency in this practice will		
	limited to, "Inte	rview: [LPN #6]			result in disciplinary action up	to	
	[LPN #6] states	s he witnessed [CNA			and including termination of th	ie	
	#4] standing in	[Resident #102's]			responsible associate.		
	room with her a	arms crossed stating, 'I			11/17/12		
	am disappointe	ed in you, I can't			11/1//12		
	believe you did	that.' [LPN #6] stated					
	that [Resident :	#102] looked upset and					
	_	NA #4] why [CNA #4					
		her] [CNA #4] then					
		oking [LPN #6] stated					
		#102] had just had a					
	_	ent [LPN #6] stated					
		[Resident #102] and					
		e done nothing wrong,					
	1	LPN #6] stated that he					
	'	102] was upset [LPN					
	_	[Resident #102]					
	_	re due to her CVA					
	-	ılar accident]. [LPN					
	_	e CNA [#4] we don't					
	i taik to resident	s in that manner"					
		tive, dated 8/17/12 at					
	· · · · · · · · · · · · · · · · · · ·	uded, but was not					
	limited to, "Inte	rview: [CNA #4]					
	[CNA #4] was a	asked if she had any					
	conversation w	rith [Resident #102] this					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155505	B. WIN	G		10/18/	2012
NAME OF B	ADOLUDED OD GLIDDLIED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	C .		6370 R	OBIN RUN W		
ROBIN R	UN HEALTH CENT	ΓER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	morning betwe	en 7:15 A.M. to 8:00					
	A.M. [CNA #4]] stated that she said to					
	[Resident #102	2] I'm disappointed in					
	you as a joke.	[Resident #102] said					
	•	I] stated because you					
		ur shirt. [CNA #4]					
		I she said to her"					
		. c caia to nor					
	A written narra	tive, dated 8/17/12 at					
	3:30 P.M., inclu	uded, but was not					
	limited to, "Inte	erview: [Resident					
		dministrator and					
	Speech Therap						
		2] due to her CVA she					
	<u> </u>	municate about the					
	alleged events						
	alleged events	•••					
	2 On 10/16/12	2 at 10:45 A.M.,					
		's record was reviewed.					
		uded, but were not					
	_						
	i iii iiieu iu, ai ixii	ety and hypertension.					
	Resident #101	was discharged home					
	on 8/17/12.	3 2 2 3 3 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3					
	An "Admission	Assessment Data"					
	nursing notes,						
	_	as not limited to,					
	·	erson, place, and					
	time"	orgon, piace, and					
	uiiic						
	 On 10/16/12 at	t 2:30 P.M., the					
		ctor provided the					
		ation in regard to an					
		_					
	allegation of Ve	erbal abuse that					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155505	B. WIN	G		10/18/	2012
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
					OBIN RUN W		
ROBIN R	UN HEALTH CENT	ER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ent #102 and CNA #4					
	on 8/17/12 at 7	':45 A.M.					
	The facility inve	estigation included the					
	"Indiana State	Department of Health:					
		t Form: Incident Date:					
	•	A.M Resident					
	Name: [Reside	ent #101] Staff					
	Name: [CNA #	4] Brief Description					
		NA [#4] was overheard					
	•	A [#7] arguing with a					
	_	lent #101] The CNA					
		esident #101's] room					
	and asked wha	•					
	_] stated she [CNA #4]					
		my own care, she					
		thing away from me					
		ne do it myself					
		on Taken: The CNA					
		ended when the vas informed [facility					
		the time] Preventive					
		en: The CNA [#4] was					
	suspended"	EII. THE CINA [#4] Was					
	suspended						
	Δ written stater	ment, dated 8/17/12 at					
		uded, but was not					
	· · · · · · · · · · · · · · · · · · ·	rview: [CNA #7]					
	· ·	in room taking care of					
		n she heard [CNA #4]					
		#101] yelling at each					
	-	ent #101] stated let me					
	_	meaning her ADL					

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505			CONSTRUCTION 00	COM	TE SURVEY IPLETED 18/2012
	PROVIDER OR SUPPLIEI		6370	T ADDRESS, CITY, STATE, ZIP ROBIN RUN W ANAPOLIS, IN 46268	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	[Resident #10] and stated [CN my stuff away myself [Res want to do it m pointed at [CN never lets me left the room A written narra 2:05 P.M., incl limited to, "Intestated she help the bathroom at there she does and help [CN resident alway and don't push is always angrithen she calms day" A written narra 3:30 P.M., incl limited to, "Intestated to, "I	4] stated no you can't 1] looked at [CNA #7] IA #4] just snatched all and won't let me do it ident #101] stated I just lyself she then A #4] and stated she do it myself [CNA #4] " Itive, dated 8/17/12 at luded, but was not lerview: [CNA #4] los [Resident #101] to land when she gets her sn't want her to stay IA #4] states the s says don't yell at me la me [Resident #101] by in the morning and s down through out the Itive, dated 8/17/12 at luded, but was not lerview: [Resident #106, lerview: [Residen				
		itive, dated 8/17/12 at uded, but was not				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155505	B. WIN			10/18/	2012
VIII OF P					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	ę.		6370 R	OBIN RUN W		
ROBIN R	UN HEALTH CENT	ΓER		INDIAN	APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
	· ·	erview: [Resident					
	#101] stated that [CNA #4] came in her room this morning and said you						
		e bathroom this					
	_	ind get out so [Resident					
		in the bathroom once					
	_	toilet [CNA #4] jerked					
		nd told her to hurry up					
	_	she stated that [CNA					
	_	other CNA's that she					
		angry [Resident					
	-	really hurt her feelings					
		veryone what I did					
	wrong"						
	2 On 10/16/11	2 at 11:00 A.M.,					
		•					
		's record was reviewed.					
	_	uded, but were not					
	limited to, pres	sure uicer.					
	Resident #100	was discharged from					
	the facility on 7	<u> </u>					
	, , , , , ,						
	A "Daily Skilled	d Nurse's Note" dated					
	6/11/12, no tim	ne, included, but was					
	· ·	'Cognitive: Alert and					
		e and situation"					
		ew Mental Status"					
	•	6/14/12 indicated a					
	score of 15 [co	gnitively intact].					
	A "Social Servi	ice Progress Notes"					
		no time, included, but					
	was not limited						
	was not illilited	ו נט, ו/כאועכוונ					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTI	TPLE CON	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	155505	A. BUILDIN	NG	00	COMPL: 10/18/2	
		155505	B. WING			10/16/	2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ROBIN R	UN HEALTH CENT	FR			DBIN RUN W APOLIS, IN 46268		
					11 0210, 111 10200	ī	Q15)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	II PR F	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	expressed a co	oncern regarding a care					
	•	ted in an allegation					
	_	estigated by the					
	Administrator a	and nursing staff"					
	On 10/16/12 at	•					
		ctor provided the					
		ation in regard to the					
	•	nysical abuse that					
		ent #100 and CNA #5					
	on 8/17/12 at 7	:45 A.M.					
	The facility inve	estigation included the					
	following:	soligation included the					
	ionownig.						
	"Indiana State	Department of Health:					
		t Form: Resident					
	Name: [Reside	ent #100] Staff					
	Involved: [CNA	\ #5] Brief					
		ncident: The resident					
	stated to one o	f our restorative nurse					
	aides [RNA #8]	='					
	_	alleges that on 6/11					
		CNA #5] is rough with					
	•	s rudely to her					
		on Taken: [CNA #5]					
	•	day the facility was					
		ncident, family notified,					
		notified Preventive en: All staff will be					
	re-educated or						
	6/20/12"	1 45436 43 01					
	0/20/12						
	A written stater	ment, dated 6/13/12 at					
		uded, but was not					
	<u> </u>	•					

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Event ID: NQP211

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/18/	ETED
	PROVIDER OR SUPPLIER		6370 RG	ODDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	at the time of the longer works at spent a long time. [Resident #100] with [CNA #5] words afraid of [Resident #100] didn't want to de the longer works at the manner of the longer works at the time of the longer works at the time of the longer works at my conversation. Resident #100] time of the incident she is doing the longer works at my conversation. Resident #100] time of the incident she incident with longer works at my conversation.	My concern is				

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Event ID: NQP211

Facility ID: 001156

If continuation sheet

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155505	B. WING		10/18/2012
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				OBIN RUN W	
KORIN K	UN HEALTH CENT	ER	INDIAN	IAPOLIS, IN 46268	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCI)	DATE
	with what she v	wants"			
	and no docume it, included, but "Conversation regarding even morning [Resid office accompate became very ureport a situation overnight [Chasweater right of hair she just she's always repushes and she	ment, no date or time entation of who wrote t was not limited to, with [Resident #100] ats of last night This lent #100] came to my unied by RNA #8 she pset she needed to on that has occurred NA #5] pulled my ff and messed up my throws things around bugh with me she oves me around she			
	land is where I rolls me over a she treats me b	he bed and where I have to stay she nd she's really rough badly I don't want her onight I'm really			
	CNA #5 was te facility on 6/18/	rminated from the 112.			
	interview, the E indicated the fa further docume the abuse inverthe allegation cabuse with Results. However, I	and the state of the indicated to the indicated to the			

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Event ID: NQP211

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		(X2) MULTIPLE CC A. BUILDING B. WING	00		LETED 3/2012
	PROVIDER OR SUPPLIE		STREET A 6370 R	ADDRESS, CITY, STATE, ZIP COI OBIN RUN W IAPOLIS, IN 46268	DE TOTAL	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
				CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	

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Event ID: NQP211

Facility ID: 001156

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155505	B. WING		10/18/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R		OBIN RUN W	
	UN HEALTH CEN	TED		IAPOLIS, IN 46268	
ROBINT	ONTILALITICLI	ILI	INDIAN		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225	483.13(c)(1)(ii)-(i				
SS=D	INVESTIGATE/F				
	ALLEGATIONS/I				
		not employ individuals who			
		guilty of abusing, streating residents by a			
		ave had a finding entered			
		rse aide registry concerning			
		nistreatment of residents or			
		of their property; and report			
		has of actions by a court of			
	law against an ei	mployee, which would			
		s for service as a nurse aide			
		taff to the State nurse aide			
	registry or licensi	ing authorities.			
	The feetlity may at	amazina that all allamad			
	-	ensure that all alleged			
		ng mistreatment, neglect, or injuries of unknown source			
		ation of resident property			
	are reported imm				
		he facility and to other			
		dance with State law			
	through establish	ned procedures (including to			
	the State survey	and certification agency).			
		have evidence that all			
	alleged violations	. .			
	_	I must prevent further			
	=	vhile the investigation is in			
	progress.				
	The results of all	investigations must be			
		dministrator or his			
		sentative and to other			
		dance with State law			
	(including to the	State survey and			
		ncy) within 5 working days of			
	the incident, and if the alleged violation is verified appropriate corrective action must				
	be taken.				
	Based on reco	rd review and	F0225	F225 Investigative/Report	11/17/2012

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Event ID: NQP211

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	ONSTRUCTION	(X3) DATE SUI	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLET	
		155505	B. WI			10/18/20	12
NAME OF D	DROVIDED OD CLIDDLIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			6370 R	OBIN RUN W		
	RUN HEALTH CENT				APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	,		DATE
		acility failed to report			Allegations/Individuals		
	. •	f alleged abuse			It is the practice of this provide	ar to	
	immediately to				not employ individuals who ha		
		during an abuse			been found guilty of abusing,		
	investigation, the	ne alleged violator was			neglecting, or mistreating		
	not suspended from work, and the				residents by a court of law; or		
	facility failed to complete a thorough				have had a finding entered int	0	
	investigation.	This deficient practice			the State nurse aide registry concerning abuse, neglect,		
	affected 2 of 2	residents [Residents			mistreatment of residents or		
	#101 and 102]	reviewed for			misappropriation of their prope	erty	
	_	buse in a sample of 15			in accordance with State and	, I	
	residents revie	• • • • • • • • • • • • • • • • • • •			Federal Law.		
		esidents reviewed for				_	
	allegations of a				What corrective action(s) wil	!	
	•	sample of 2 residents			be accomplished for those residents found to have been		
	reviewed. [Res	-			affected by the deficient	1	
	reviewed. [Res	ident#100j			practice:		
	Findings includ	e:					
	1 On 10/16/12	at 10:15 A.M.,			Residents #100, #101, and #1	02	
		s record was reviewed.			were discharged from the community.		
		uded, but were not			Community.		
		etes mellitus type II,			How other residents having	the	
	i riyperterision, a	and acute renal failure.			potential to be affected by th		
	B	P 1 16			same deficient practice will be		
		was discharged from			identified and what correctiv	e	
	the facility on 1	0/12/12.			action(s) will be taken:		
	An "Admission	Evaluation Data"			Staff will be advected recording		
	nursing assessment, dated 8/9/12, indicated Resident #102 was alert to				Staff will be educated regardir abuse and abuse reporting by	-	
					Director of Nursing and the	110	
	self.				Executive Director.		
	A "Coole! Carri	oo Drogroop Notell			The Director of Nursing and th	ie	
		ce Progress Note"			Executive Director will re-educ		
	dated 8/16/12,	included, but was not			staff on the appropriate	[

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		155505	B. WING			10/18/	2012
NAME OF F	PROVIDER OR SUPPLIEF	8		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					OBIN RUN W		
ROBIN R	RUN HEALTH CENT	TER		INDIAN	APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		sident is alert and			procedures of abuse investigations, including report	tina	
		son. Resident requires			allegations of abuse immediate	•	
		n ADL's [activities of			The community will continue to	•	
	daily living] She is able to respond				suspend associates whom have		
	to direct communication pleasant				had an allegation of abuse ma		
	and cooperative with care"				against them, and will continue thoroughly investigate and	e to	
					document investigations of		
		t 2:30 A.M., the			allegations of abuse.		
		ctor provided the					
	, , ,	ation for an allegation					
	of abuse on 8/	17/12 at 7:20 A.M.			What measures will be put in	ito	
					place or what systemic changes will be made to		
	The abuse investigation included, but				ensure that the deficient		
	was not limited	I to, the following:			practice does not recur:		
		Department of Health:			An abuse Quality Assurance		
		t Form: Incident Date:			Performance Improvement autool will be completed once	ait	
		A.M Resident's			weekly times 4 weeks, then		
	Name: [Reside	ent #102] Staff			bi-weekly times 4 weeks, then		
	Involved: [Cer	tified Nursing Assistant]			quarterly until the alleged		
	CNA #4 Brie	f Description of			deficient practice does not rec	ur.	
	Incident: The	CNA [#4] was observed					
		nurse [Licensed					
	Practical Nurse	e #6] standing looking			How the corrective action(s)		
		with her arms folded			will be monitored to ensure t	he	
	saying 'I'm disa	appointed in you. I			deficient practice will not rec	ur,	
	can't believe yo	ou did this.' The			i.e., what quality assurance		
		st had a bowel			program will be put into plac	e:	
	movement. Th	nis resident is			The abuse Quality Assurance		
	incontinent Ir	nmediate Action: The			Performance Improvement au	dit	
	CNA [#4] was removed from the				tool will be reviewed in the		
		tive Measures Taken:			monthly Quality Assurance		
	CNA [#4] was	advised by the charge			Performance Improvement		
		that we do not talk to			meeting by the Quality Assura Committee.	nce	
		scolding manner"			Committee.		
		<u> </u>					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 10/18/	ETED	
	PROVIDER OR SUPPLIER			6370 R	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	1:30 P.M., includimited to, "Intellimited to, "I	tive, dated 8/17/12 at uded, but was not rview: [LPN #6] as he witnessed [CNA [Resident #102's] arms crossed stating, 'I ad in you, I can't at that.' [LPN #6] stated #102] looked upset and cNA #4] why [CNA #4 her] [CNA #4] then oking [LPN #6] stated #102] had just had a sent [LPN #6] stated [Resident #102] and se done nothing wrong, LPN #6] stated that he stated that			Deficiency in this practice will result in disciplinary action up and including termination of the responsible associate. 11/17/2012		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE CO	00	COM	TE SURVEY MPLETED 18/2012
	PROVIDER OR SUPPLIER		6370 R	ADDRESS, CITY, STATE, ZIP O OBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE .	HOULD BE	(X5) COMPLETION
TAG	A.M. [CNA #4] [Resident #102] you as a joke. why? [CNA #4] unbuttoned you stated that's all The written narror did not indicate by. A written narra 3:30 P.M., includinated to, "Interested #102] The Additional Speech Therap [Resident #102] would not comalleged events.	2] due to her CVA she municate about the"	TAG	DEFICIENCY)		DATE
	allegation. In a documentation #102's closed of On 10/17/12 at Executive Dire facility's sched 8/17/12. The schedule in CNA #4 as have	estigation of the abuse addition, there was no located in Resident clinical record. It 9:00 A.M., the ctor provided the ule as worked, dated in a worked the 1st 2 P.M.] on 8/17/12.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155505	B. WIN	G		10/18/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	ROVIDER OR SOLVER	•			OBIN RUN W		
ROBIN R	RUN HEALTH CENT	ΓER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		facility before her					
	scheduled shift	t ended on 8/17/12.					
	On 40/47/40 at 44:00 A M in an						
		t 11:00 A.M., in an					
		Executive Director					
		acility did not have any					
		entation to provide for					
		stigation that involved					
	_	of verbal abuse with					
	Resident #102	by CNA #4.					
	ام ماطنانم م	Evenutive Director					
	·	Executive Director since he was not					
	l ·	Executive Director, he					
	could not verify						
		at that time, was					
		ncident, if CNA #4 was					
	•	mediately, or if a more					
	thorough inves	augation was					
	completed.						
	2 On 10/16/19	2 at 10:45 A.M.,					
		's record was reviewed.					
		uded, but were not					
		ety and hypertension.					
	ininiteu tu, anxi	ety and hypertension.					
	Resident #101	was discharged home					
	on 8/17/12.	was discharged nome					
	511 0/ 17/ 12.						
	An "Admission	Assessment Data"					
	nursing notes,						
	•	vas not limited to,					
	· · · · · · · · · · · · · · · · · · ·	erson, place, and					
	time"	noon, piaco, ana					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155505	B. WIN	G		10/18/	2012
NAME OF F	PROVIDER OR SUPPLIEF		_	STREET A	DDRESS, CITY, STATE, ZIP CODE		
					OBIN RUN W		
ROBIN R	RUN HEALTH CENT	ΓER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		t 2:30 P.M., the					
		ctor provided the					
	, ,	ation in regard to an					
	_	erbal abuse that					
	involved Resident #102 and CNA #4 on 8/17/12 at 7:45 A.M.						
	•	estigation included the					
	following:						
	"Indiana Stata	Department of Health					
	"Indiana State Department of Health: Incident Report Form: Incident Date:						
	•	5 A.M Resident					
	_	ent #101] Staff					
	-	#4] Brief Description					
		NA [#4] was overheard					
		A [#7] arguing with a					
	_	dent #101] The CNA					
		esident #101's] room					
	and asked wha	<u> </u>					
	l -	1] stated she [CNA #4]					
		my own care, she					
		thing away from me					
		ne do it myself					
		ion Taken: The CNA					
		ended when the					
		was informed [facility					
		y the time] Preventive					
		en: The CNA [#4] was					
	suspended"						
	A						
		ment, dated 8/17/12 at					
	•	uded, but was not					
		erview: [CNA #7]					
	states she was	in room taking care of					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/18/2012
	PROVIDER OR SUPPLIE		6370 F	ADDRESS, CITY, STATE, ZIP CODE ROBIN RUN W NAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	and [Resident other [Reside do this myself, care [CNA # [Resident #10] and stated [CN my stuff away myself [Res want to do it m pointed at [CN never lets me left the room A written narra 2:05 P.M., incl limited to, "Intestated she help the bathroom at there she does and help [CN resident alway and don't push is always angrethen she calms day" A written narra 3:30 P.M., incl limited to, "Intestated to, "Intestated to, "Intestated she help the bathroom at	en she heard [CNA #4] #101] yelling at each ent #101] stated let me meaning her ADL 4] stated no you can't 1] looked at [CNA #7] IA #4] just snatched all and won't let me do it ident #101] stated I just lyself she then A #4] and stated she do it myself [CNA #4] " Itive, dated 8/17/12 at luded, but was not erview: [CNA #4] los [Resident #101] to land when she gets her sn't want her to stay IA #4] states the s says don't yell at me la me [Resident #101] by in the morning and s down through out the Itive, dated 8/17/12 at luded, but was not erview: [Resident #106, 's roommate] states a lot I do know the lyas exasperated with because she takes so gs She [CNA #4] had			

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Event ID: NQP211

Facility ID: 001156

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/18/2012
	PROVIDER OR SUPPLIEI		6370 F	ADDRESS, CITY, STATE, ZIP CODE ROBIN RUN W NAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	A written narra 4:20 P.M., incl limited to, "Interest going in the morning now a #106] can get she got on the her gown off a and get out \$ #4] would tell always gets up #101] stated it that she told e wrong" There was no the investigation on 8/17/12 at 70 On 10/17/12 at Executive Direct facility's sched 8/17/12. The schedule CNA #4 as has shift [6 A.M. to There was no #4 leaving the	ative, dated 8/17/12 at uded, but was not erview: [Resident that [CNA #4] came in morning and said you e bathroom this and get out so [Resident in the bathroom once toilet [CNA #4] jerked and told her to hurry up she stated that [CNA other CNA's that she of angry [Resident really hurt her feelings weryone what I did other documentation in on or the resident's regarding the incident 7:45 A.M. It 9:00 A.M., the ector provided the ule as worked, dated included the name of wing worked the 1st 2 P.M.] on 8/17/12. documentation of CNA facility before her it ended on 8/17/12.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S	ETED	
		155505	B. WIN			10/18/	2012
	PROVIDER OR SUPPLIEF			6370 R	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	On 10/17/12 at interview, the E indicated the fa further docume the abuse inverted abuse with Research as the could not verify Administrator, notified of the insuspended impresent as the could not verify Administrator, notified of the insuspended impresent as the could not verify Administrator, notified of the insuspended impresent as the could not verify Administrator, notified of the insuspended impresent as the could not verify Administrator, notified of the insuspended impresent as the could not verify Administrator, notified of the insuspended impresent involved invol	at that time, was incident, if CNA #4 was mediately, or if a more stigation was 2 at 11:00 A.M., 's record was reviewed. luded, but were not sure ulcer. was discharged from		TAG			DATE

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Event ID: NQP211

Facility ID: 001156

If continuation sheet

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l í í			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE :	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155505	B. WIN	G		10/18/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					OBIN RUN W		
ROBIN R	UN HEALTH CENT	ER		INDIAN.	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	score of 15 [co	gnitively intact].					
	A "Social Servi dated 6/13/12, was not limited expressed a cogiver that resul that will be inversed. On 10/16/12 at Executive Direct facility investigallegation of phinvolved Resident on 8/17/12 at 7. The facility investigallegation of phinvolved Resident Proposition of Involved: [CNATION Description Descr	encern regarding a care ted in an allegation estigated by the and nursing staff" 2:30 P.M., the ctor provided the ation in regard to the ation in regard to the aysical abuse that ent #100 and CNA #5 (2:45 A.M.) Estigation included the Department of Health: the Form: Resident ent #100] Staff A #5] Brief incident: The resident four restorative nurse					
		en: All staff will be					

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Event ID: NQP211

Facility ID: 001156

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NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COM	TE SURVEY SPLETED 18/2012
PROVIDER OR SUPPLIER		6370	ET ADDRESS, CITY, STATE, ZIP) ROBIN RUN W ANAPOLIS, IN 46268	CODE	
SUMMARY S (EACH DEFICIENT REGULATORY OR re-educated or 6/20/12" A written stater 7:41 A.M., including the time of the longer works a spent a long tir [Resident #100] with [CNA #5] words afraid of [Resident #100] didn't want to of #8] brought her relayed her conthrows things at them As you had a situation who was no long facility] and can him She [CN assignments [Resident #100] resident #100] resident #100] resident #100] resident #100]	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) The abuse as of The abus	6370	PROBIN RUN W ANAPOLIS, IN 46268 PROVIDER'S PLAN OF CO	ORRECTION SHOULD BE	(X5) COMPLETION DATE
A written stater 2:10 P.M., including limited to, "From at the time of the longer works a	ment, dated 6/15/12 at uded, but was not m [Director of Nursing he incident who no the facility] Just had on with [Resident #29,				

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Event ID: NQP211

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IDENTIFICATION NUMBER IDENTIFICATION IDENTIFICATIO	i î		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER SIMMARY STATEMENT OF DEFICIENCIES RECOLLATORY OR LSC (DENTIFYING INFORMATION) RECOLLATION RECOLLATION	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
ROBIN RUN HEALTH CENTER ROBIN RUN HEALTH CENTER SIMMARY STATEMENT OF DEFICIENCIES PREFIX TAG Resident #100's roommate at the time of the incident] [Resident #29] confirms she heard [CNA #5] get frustrated with [Resident #100] because [Resident #100] is particular with what she wants" A written statement, no date or time and no documentation of wrote it, included, but was not limited to, "Conversation with [Resident #100] regarding events of last night This morning [Resident #100] came to my office accompanied by RNA #8 she became very upset she needed to report a situation that has occurred overnight [CNA #5] pulled my sweater right off and messed up my hair she just throws things around she's always rough with me she pushes and shoves me around she throws me on the bed and where I land is where I have to stay she rolls me over and she's really rough she treats me badly I don't want her to be my aide tonight I'm really afraid of her" There was no other documentation regarding in the facility investigation in the resident's clinical record. On 10/17/12 at 9:00 A.M., the			155505				10/18/	2012
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On 10/17/12 at 9:00 A.M., the			•					
		On 10/17/12 at	t 9:00 A.M., the					
Executive Director provided the		Executive Dire	ctor provided the					
facility's schedule as worked, dated		facility's sched	ule as worked, dated					

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Event ID: NQP211

Facility ID: 001156

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	155505	A. BUIL	DING	00	COMPL 10/18/	
		100000	B. WING	_		10/16/	2012
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W		
ROBIN R	RUN HEALTH CEN	TER			APOLIS, IN 46268		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	6/13/12.	(LSC IDENTIFYING INFORMATION)		TAG	DLI ICILICI I		DATE
	0/13/12.						
	The schedule	included the name of					
		ving worked the 2nd					
		10 P.M.] on 6/13/12.					
		10 1					
	CNA #5 was te	erminated from the					
	facility on 6/18						
	On 10/17/12 a	t 11:00 A.M., in an					
	interview, the I	Executive Director					
	indicated the fa	acility did not have any					
		entation to provide for					
		estigation that involved					
		of verbal and physical					
		sident #100 by CNA					
	#5.						
	In addition the	e Executive Director					
	· ·	since he was not					
		Executive Director, he					
	could not verify						
		at that time, was					
		incident, if CNA #5 was					
		mediately, or if a more					
	thorough inves	•					
	completed.	-					
	3.1-28(c)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NQP211

Facility ID: 001156

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155505	B. WING			10/18/	2012
			B. WIIW		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OBIN RUN W		
DODINI D	UN HEALTH CENT	·ED			APOLIS, IN 46268		
KOBIN K	ONTICALITICENT	EN		INDIAN	AFOLIS, IN 40200		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0226	483.13(c)						
SS=D		MENT ABUSE/NEGLECT,					
	ETC POLICIES						
		develop and implement					
	•	nd procedures that prohibit					
		glect, and abuse of cappropriation of resident					
	property.	sappropriation of resident					
	Based on reco	rd review and	F022	26	F226 Develop/Implement		11/17/2012
			1.027	20	Abuse/Neglect, Policies		11/1//2012
	·	acility failed to ensure			Abuse/Neglect, Folicies		
		phibition Policies were			It is the practice of this provide	r to	
	followed related	d to reporting alleged			develop and implement written		
	abuse immedia	itely to the			policies and procedures that		
	Administrator, t	the facility failed to			prohibit mistreatment, neglect,		
	follow their poli	cy related to protection			and abuse of residents and		
	•	ring an alleged abuse			misappropriation of resident		
		s the alleged violator			property.		
	_	•					
	-	nded from work, and			What corrective action(s) will		
		ghly investigate the			be accomplished for those		
	allegations of a	buse. The deficient			residents found to have been	l	
	practice impact	ted 2 of 2 residents			affected by the deficient		
	[Residents #10	1 and 102] reviewed			practice:		
	for allegations	of abuse in a sample					
	•	reviewed and 1 of 2			Posident #100 #101 and #10	2	
		wed for allegations of			Resident #100, #101, and #10 have been discharged from the		
		•			community.	•	
	•	plemental sample of 2			Community.		
	residents revie	wed. [Resident #100]					
					How other residents having t	he	
	Findings includ	e:			potential to be affected by the		
					same deficient practice will b		
	1. On 10/16/12	at 10:15 A.M.,			identified and what corrective	9	
		s record was reviewed.			action(s) will be taken:		
		uded, but were not					
	_	etes mellitus type II,					
		• •			Staff will be educated regardin	-	
	riyperterision, a	and acute renal failure.			abuse and abuse reporting by	the	
					Director of Nursing and the		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLE	ETED
		155505	B. WIN			10/18/2	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OBIN RUN W		
ROBIN R	RUN HEALTH CENT	ΓER			IAPOLIS, IN 46268		
					GEIG, III 16266	1	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	Executive Director.	+	DATE
		was discharged from			Executive Director.		
	the facility on 10/12/12.				The Director of Nursing and th	ne	
					Executive Director will re-educ		
	An "Admission	Evaluation Data"			staff on the appropriate		
	nursing assess	sment, dated 8/9/12,			procedures of abuse		
	indicated Resid	dent #102 was alert to			investigations, including repor	-	
	self.				allegations of abuse immediat	•	
					The community will continue to suspend associates whom har		
	A "Social Serv	ice Progress Note"			had an allegation of abuse ma		
		included, but was not			against them, and will continue		
		sident is alert and			thoroughly investigate and		
		son. Resident requires			document investigations of		
	•	n ADL's [activities of			allegations of abuse.		
		She is able to respond					
	, , , , , , , , , , , , , , , , , , , ,	•			What massures will be put in		
		unication pleasant			What measures will be put in place or what systemic		
	and cooperativ	e with care"			changes will be made to		
					ensure that the deficient		
		t 2:30 A.M., the			practice does not recur:		
		ctor provided the					
		ation for an allegation					
	of abuse on 8/	17/12 at 7:20 A.M.			An abuse Quality Assurance		
					Performance Improvement au	dit	
	The abuse inve	estigation included, but			tool will be completed once weekly times 4 weeks, then		
	was not limited	I to, the following:			bi-weekly times 4 weeks, then		
		-			quarterly until the alleged		
	I "Indiana State	Department of Health:			deficient practice does not rec	ur.	
		t Form: Incident Date:					
		A.M Resident's					
		ent #102] Staff			How the corrective action(s)		
	-	tified Nursing Assistant]			will be monitored to ensure t		
	_	•			deficient practice will not rec i.e., what quality assurance	ur,	
	CNA #4 Brief Description of Incident: The CNA [#4] was observed				program will be put into place	:e:	
					P. Salam will be but into blue		
	1 '	nurse [Licensed					
		e #6] standing looking			The abuse Quality Assurance		
	at the resident	with her arms folded			Performance Improvement au		

	OF CORRECTION OF CORRECTION 155505 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 10/18/2012
	PROVIDER OR SUPPLIER	6370 R	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W IAPOLIS, IN 46268	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	saying 'I'm disappointed in you. I can't believe you did this.' The resident had just had a bowel movement. This resident is incontinent Immediate Action: The CNA [#4] was removed from the room Preventive Measures Taken: CNA [#4] was advised by the charge nurse [LPN #6] that we do not talk to residents in a scolding manner" A written narrative, dated 8/17/12 at 1:30 P.M., included, but was not limited to, "Interview: [LPN #6] [LPN #6] states he witnessed [CNA #4] standing in [Resident #102's] room with her arms crossed stating, 'I am disappointed in you, I can't believe you did that.' [LPN #6] stated that [Resident #102] looked upset and finally asked [CNA #4] why [CNA #4 was upset with her] [CNA #4] then said I am just joking [LPN #6] stated that [Resident #102] had just had a bowel movement [LPN #6] stated that he went to [Resident #102] and stated you have done nothing wrong, you are fine [LPN #6] stated that he felt [Resident #102] was upset [LPN #6] stated that [Resident #102] cannot verbalize due to her CVA [cerebral vascular accident]. [LPN #6] advised the CNA [#4] we don't talk to residents in that manner"		tool will be reviewed in the monthly Quality Assurance Performance Improvement meeting by the Quality Assura Committee. Deficiency in this practice will result in disciplinary action up and including termination of the responsible associate.	to

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NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
ROBIN F	RUN HEALTH CEN	TER		OBIN RUN W JAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
		rrative was not signed cate who it was written			
	2:05 P.M., incl limited to, "Inte [CNA #4] was conversation was morning betwee A.M. [CNA #4] [Resident #10] you as a joke. why? [CNA #4] unbuttoned you stated that's all the written na	ative, dated 8/17/12 at uded, but was not erview: [CNA #4] asked if she had any with [Resident #102] this een 7:15 A.M. to 8:00 .] stated that she said to 2] I'm disappointed in [Resident #102] said 4] stated because you ur shirt. [CNA #4] Il she said to her"			
	3:30 P.M., incl limited to, "Inte #102] The A Speech Thera [Resident #10] would not com alleged events There was no the facility inve allegation. In documentation	ative, dated 8/17/12 at uded, but was not erview: [Resident dministrator and py interviewed 2] due to her CVA she amunicate about the s" other documentation in estigation of the abuse addition, there was no a located in Resident clinical record.			

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE S	
ANDIEM	or connection	155505	A. BUII B. WIN	LDING G	00	10/18/	
	PROVIDER OR SUPPLIER		D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268	<u> </u>	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Executive Dire facility's sched 8/17/12. The schedule in CNA #4 as have shift [6 A.M. to There was noted at the fact that interview, the Eindicated the fact further document the abuse inverting the allegation of Resident #102. In addition, the indicated that is present as the could not verify Administrator, notified of the interview of the indicated of the interview of the indicated that is present as the could not verify Administrator, notified of the interview of the interv	Executive Director since he was not Executive Director, he when the at that time, was notident, if CNA #4 was mediately, or if a more					
	Resident #101 Diagnoses incl	2 at 10:45 A.M., 's record was reviewed. uded, but were not ety and hypertension.					

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	of correction (X1) Provider/St IDENTIFICATION 155505	NUMBER:	X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 10/18/2012
	PROVIDER OR SUPPLIER		6370 RG	DDRESS, CITY, STATE, ZIP CODE DBIN RUN W APOLIS, IN 46268	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DE (EACH DEFICIENCY MUST BE PREC REGULATORY OR LSC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Resident #101 was dischar on 8/17/12.	ged home			
	An "Admission Assessment nursing notes, dated 7/30/1 included, but was not limite "Oriented to person, place, time"	2, d to,			
	On 10/16/12 at 2:30 P.M., t Executive Director provided facility investigation in regal allegation of verbal abuse to involved Resident #102 and on 8/17/12 at 7:45 A.M.	t the rd to an hat			
	The facility investigation inc following:	cluded the			
	"Indiana State Department Incident Report Form: Incident Report Form: Incident Report Form: Incident Resident Resident Resident Resident Resident Resident Resident: CNA Resident Resident: CNA Resident	dent Date: ident Staff escription overheard ng with a The CNA I's] room [CNA #4] re, she from me			

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	T OF DEFICIENCIES						
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155505	B. WING	<u> </u>		10/18/	2012
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
DODIN D	LINI LIEAL TIL OFNIT	TED			OBIN RUN W		
ROBIN R	UN HEALTH CENT	ER		INDIAN	APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ended when the					
		vas informed [facility					
		the time] Preventive					
		en: The CNA [#4] was					
	suspended"						
	A writton state:	mont dated 0/17/12 at					
		ment, dated 8/17/12 at uded, but was not					
	-	rview: [CNA #7]					
	-	in room taking care of					
		n she heard [CNA #4]					
		#101] yelling at each					
	_	ent #101] stated let me					
	_	meaning her ADL					
		1] stated no you can't					
	-] looked at [CNA #7]					
	_ -	IA #4] just snatched all					
	-	and won't let me do it					
		dent #101] stated I just					
	_	yself she then					
		A #4] and stated she					
		do it myself [CNA #4]					
	left the room'						
	A written narra	tive, dated 8/17/12 at					
		uded, but was not					
	-	rview: [CNA #4]					
		os [Resident #101] to					
	•	and when she gets her					
		n't want her to stay					
		IA #4] states the					
	resident always	s says don't yell at me					
	-	me [Resident #101]					
	is always angr	y in the morning and					
	then she calms	down through out the					
	and help [CN resident always and don't push is always angry	IA #4] states the s says don't yell at me me [Resident #101] y in the morning and					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505			(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/18/2012
	PROVIDER OR SUPPLIE		6370 F	ADDRESS, CITY, STATE, ZIP CODE ROBIN RUN W NAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
TAG	day" A written narra 3:30 P.M., incl limited to, "Inte Resident #101 she didn't hear girl [CNA #4] v my roommate long to do thin to be forceful t A written narra 4:20 P.M., incl limited to, "Inte #101] stated her room this r are going in th morning now a #106] can get she got on the her gown off a and get out s #4] would tell o always gets up #101] stated it	ative, dated 8/17/12 at uded, but was not erview: [Resident #106, 's roommate] states a lot I do know the was exasperated with because she takes so gs She [CNA #4] had to get her to move" ative, dated 8/17/12 at uded, but was not erview: [Resident that [CNA #4] came in morning and said you be bathroom this and get out so [Resident in the bathroom once toilet [CNA #4] jerked and told her to hurry up she stated that [CNA bother CNA's that she or angry [Resident really hurt her feelings veryone what I did	TAG		
	the investigation clinical record on 8/17/12 at 7	other documentation in on or the resident's regarding the incident 7:45 A.M. t 9:00 A.M., the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155505	A. BUII	LDING	00	COMPLE 10/18/2	
		100000	B. WIN			10/10/2	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W		
ROBIN R	RUN HEALTH CEN	TER			APOLIS, IN 46268		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ector provided the					
	8/17/12.	ule as worked, dated					
	0/1//12.						
	The schedule	included the name of					
		ving worked the 1st					
		2 P.M.] on 8/17/12.					
	There was no	documentation of CNA					
	#4 leaving the	facility before her					
	scheduled shif	t ended on 8/17/12.					
	0: 40/47/40 -	4.44.00 A.M. Salara					
		t 11:00 A.M., in an Executive Director					
	· ·	acility did not have any					
		entation to provide for					
		estigation that involved					
		of verbal and physical					
		sident #101 by CNA					
	#4.						
		Executive Director					
		since he was not					
	could not verify	Executive Director, he					
	·	at that time, was					
	· · · · · · · · · · · · · · · · · · ·	incident, if CNA #4 was					
		mediately, or if a more					
	thorough inves	•					
	completed.	-					
		2 at 11:00 A.M.,					
		's record was reviewed.					
	1	luded, but were not					
	limited to, pres	Soure uicei.					
I	I		- 1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED					
AND PLAN	OF CORRECTION	155505		A. BUILDING 10/18/2012			
		100000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	10/10/	2012
NAME OF P	ROVIDER OR SUPPLIER	l .			OBIN RUN W		
ROBIN R	UN HEALTH CENT	ER			APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION DATE
IAG		was discharged from		IAG	,		DATE
	the facility on 7	~					
	Δ "Daily Skiller	l Nurse's Note" dated					
	_	e, included, but was					
		Cognitive: Alert and					
		e and situation"					
	Δ "Rrief Intervi	ew Mental Status"					
	completed on 6/14/12 indicated a score of 15 [cognitively intact].						
	•	J , 1					
	A "Social Servi	ce Progress Notes"					
		no time, included, but					
	was not limited	·					
	•	oncern regarding a care					
	_	ted in an allegation estigated by the					
		and nursing staff"					
	Administrator e	and naroling stan					
	On 10/16/12 at	: 2:30 P.M., the					
		ctor provided the					
		ation in regard to the					
		nysical abuse that					
		ent #100 and CNA #5					
	on 8/17/12 at 7	.IVI.A C+.					
	The facility inve	estigation included the					
	following:	•					
		Department of Health:					
	•	t Form: Resident					
	Involved: [CN/	ent #100] Staff					
	_	Incident: The resident					
		molaciii. The resident					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	BUILDING COMPLETED			ETED
		155505	B. WIN			10/18/	2012
(F. 0F. P				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	£		6370 R	OBIN RUN W		
ROBIN R	RUN HEALTH CENT	TER		INDIAN	APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		of our restorative nurse					
	aides [RNA #8]						
	-)] alleges that on 6/11					
	· -	CNA #5] is rough with					
	•	s rudely to her					
		ion Taken: [CNA #5]					
	•	day the facility was					
		ncident, family notified,					
		notified Preventive					
		en: All staff will be					
	re-educated or	n abuse as of					
	6/20/12"						
	A						
		ment, dated 6/13/12 at					
	· ·	uded, but was not					
		m [Director of Nursing					
		he incident who no					
	•	t the facility] I just					
	'	me speaking with					
	-)] she is very upset					
		Actually in her own					
		her [CNA #5]					
	-)] was in tears she					
		liscuss this but [RNA					
		r to my office and she					
	1	ncerns She [CNA #5]					
		at me when I ask for					
		recall, [CNA #5] also					
		with [another resident,					
		nger a resident at the					
	, , ,	n no longer care for					
	him She [CN	. 0					
	assignments	-					
	[Resident #100						
	resident] are no	ot the only residents					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/18/2012
	PROVIDER OR SUPPLIEI		6370 R	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W IAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		is to It broke my tesident #100] so			
	2:10 P.M., incl limited to, "Fro at the time of t longer works a my conversation Resident #100 time of the incl confirms she has	ment, dated 6/15/12 at uded, but was not m [Director of Nursing he incident who no at the facility] Just had on with [Resident #29, 's roommate at the dent] [Resident #29] leard [CNA #5] get [Resident #100] dent #100] is particular wants"			
	and no documincluded, but we "Conversation regarding ever morning [Residual office accompates and states overnight [Classeater right of the conversion of	ment, no date or time entation of wrote it, was not limited to, with [Resident #100] hats of last night This dent #100] came to my anied by RNA #8 she upset she needed to on that has occurred NA #5] pulled my off and messed up my throws things around bough with me she noves me around she the bed and where I have to stay she and she's really rough badly I don't want her			

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Event ID: NQP211

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155505	B. WIN	G		10/18/	2012
NAME OF P	PROVIDER OR SUPPLIER	8		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
			6370 ROBIN RUN W				
ROBIN R	UN HEALTH CENT	ΓER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
to be my aide tonight I'm really							
	afraid of her"						
	There was no	other documentation					
	regarding in the	e facility investigation in					
	the resident's o	clinical record.					
	On 10/17/12 at	t 9:00 A.M., the					
	Executive Dire	ctor provided the					
	facility's sched	ule as worked, dated					
	6/13/12.						
	The schedule i	ncluded the name of					
	CNA #5 as hav	ring worked the 2nd					
	shift [2 P.M. to	10 P.M.] on 6/13/12.					
	-	-					
	CNA #5 was te	erminated from the					
	facility on 6/18/	/12.					
	On 10/17/12 at	t 11:00 A.M., in an					
		Executive Director					
	•	acility did not have any					
		entation to provide for					
		stigation that involved					
		of verbal and physical					
	_	sident #100 by CNA					
	#5.	SIGGIIL # 100 DY GINA					
	πJ.						
	In addition the	Executive Director					
	· · · · · · · · · · · · · · · · · · ·	since he was not					
		Executive Director, he					
	· •	·					
	could not verify						
		at that time, was					
		ncident, if CNA #5 was					
	suspended imr	mediately, or if a more					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	thorough investigation completed.	stigation was						
	3.1-28(a)							

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Event ID: NQP211

Facility ID: 001156

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155505			(X2) M A. BUII B. WIN	LDING	OO	(X3) DATE (COMPL 10/18/	ETED
	ROVIDER OR SUPPLIER UN HEALTH CENT			6370 R	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
F0241 SS=D	in a manner and i maintains or enhadignity and respector her individuality. Based on observed record review, maintain the digwhile they were meal. This affeobserved being observation in (Resident #13) Findings include The clinical record review, maintain the digwhile they were meal. This affeobserved being observation in (Resident #13) Findings include The clinical record Resident #13 with 10/17/12 at 3:1 included, but with 10/15/12 at 1:2 dining room. The residents sitting was observed sitting was observe	promote care for residents in an environment that ances each resident's ct in full recognition of his y. rvation, interview and the facility failed to gnity of a resident e being fed during a ected 1 of 1 resident great during a meal a sample of 15. e: ord review for yas completed on 5 P.M. Diagnoses ere not limited to, legal	F02	41	F241 Dignity and Respect of Individuality It is the practice of the provide promote care for residents in a manner and in an environmen that maintains or enhances earesident's dignity and respect full recognition of his or her individuality. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Staff were re-educated on how assist Resident #13 at meal times. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Staff will be re-educated on	r to a t ch in	11/17/2012

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Event ID: NQP211

Facility ID: 001156

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155505	B. WIN			10/18/2012
NAME OF B	DOLUBED OD GUDDU IEI				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF	C		6370 R	OBIN RUN W	
	UN HEALTH CENT	TER		INDIANAPOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE
	up.				facility policy on assistance with meals by the Director of Nursii	
	In an interview at the daily conference on 10/17/12 at 3:45 P.M., R.N. #13				and Dietary Manager.	19
					and Dietary managem	
		should not be standing			What measures will be put in	to
	up while feedir	ng a resident.			place or what systemic	
					changes will be made to	
	3.1-3(t)				ensure that the deficient practice does not recur:	
					practice aces flot recur.	
					Staff were re-educated on faci	-
					policy on assistance with meal	
					by the Director of Nursing and	
					Dietary Manager to maintain resident dignity and respect	
					during meal times.	
					How the corrective action(a)	
					How the corrective action(s) will be monitored to ensure t	ho
					deficient practice will not rec	-
					i.e., what quality assurance	,
					program will be put into plac	e:
					A dignity and respect Quality	
					Assurance Performance	
					Improvement audit tool will be	
					utilized weekly times 4 weeks,	
					then bi-weekly times 4 weeks	and
					then monthly until the alleged deficient practice does not rec	ur
					denoient practice aces not rec	ui.
					The Quality Assurance	
					Performance Improvement au	
					will be reviewed in the monthly	
					Quality Assurance Performance	ce
					Improvement meeting by the Quality Assurance committee.	
					adding / local alloc committee.	

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PRINTED: 11/21/2012 FORM APPROVED OMB NO. 0938-0391

10/18/2012
(X5) COMPLETION DATE

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Event ID: NQP211

Facility ID: 001156

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155505	B. WING		10/18/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				
DODIN D	LINI LICAL TU CENT	TED		ROBIN RUN W	
ROBIN R	UN HEALTH CENT	ER	INDIA	NAPOLIS, IN 46268	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION)		DEFICIENCY)	DATE
F0279	483.20(d), 483.20	O(k)(1)			
SS=D	DEVELOP COMP	PREHENSIVE CARE			
	PLANS				
		e the results of the			
		evelop, review and revise			
	the resident's con	nprehensive plan of care.			
	•	develop a comprehensive			
		n resident that includes			
	•	ctives and timetables to			
		medical, nursing, and nosocial needs that are			
		omprehensive assessment.			
		ompremensive assessment.			
	The care plan mu	ist describe the services			
	•	nished to attain or maintain			
	the resident's high	hest practicable physical,			
		hosocial well-being as			
	required under §4	183.25; and any services			
		ise be required under			
	_	not provided due to the			
		e of rights under §483.10,			
		t to refuse treatment under			
	§483.10(b)(4).				
		nterview and record	F0279	F279 Develop Comprehensiv	e 11/17/2012
	review, the faci	ility failed to develop		Care Plans	
	individualized b	pehavior interventions			
	to use for 1 of 8	8 residents who were		It is the practice of the provide	
		iving behaviors in a		use the results of the assessm	
		esidents reviewed.		to develop, review and revise t	
				resident's comprehensive plan	Of
	[Resident #47]			care.	
	B. Based on in	nterview and record		What corrective action(s) will	
	review, the faci	lity failed to ensure		be accomplished for those	·
	that a coordina	ted Care Plan was		residents found to have been	,
		onjunction between the		affected by the deficient	-
	•	ospice agency, which		practice:	
	•				
	clearly outlined	•		Resident #47 had their care pl	an
	responsibilities	and services to be		customized for resident specifi	c

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SU	JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			TED	
		155505	B. WIN			10/18/2	012
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			OBIN RUN W		
ROBIN R	RUN HEALTH CENT	ΓER			IAPOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	provided by ea	ich; for 2 of 2 residents			interventions to address		
	reviewed who	were receiving Hospice			behaviors exhibited by resider	nt.	
		sample of 15 residents.			Care Plans will continue to be		
	[Residents #26	-			updated as needed depending		
	[(100/00/110/1120				the behavior that was exhibite resident.	и Бу	
	Eindingo inglus	No:			resident.		
	Findings includ	JC.			Resident #26 we implemented	la	
					combined care plan with facilit		
		rview during the initial			and Hospice provider and crea		
		r on 10/15/12 at 11:05			an interdisciplinary care plan v		
	A.M., L.P.N. #	1 indicated Resident			Hospice and Facility. Facility		
	#47 had episod	des of agitation, and			conducted a Care Plan on		
	would "throw th	hings." The nurse			11/7/12 in attendance was Fac	cility	
		esident was hard of			staff and Hospice staff and		
		used to wear her			resident #26 family. During ca		
					plan on 11/7/12 residents over plan of care was reviewed.	all	
		nd had episodes of			Multiple Data Set will have		
		or take a nutritional			significant revisions with result	t to	
	supplement.				cause and care plans.		
	The clinical rea	eard for Decident #47					
		cord for Resident #47			Desident #02 we insulance at a		
		on 10/15/12 at 1:00			Resident #63 we implemented combined care plan with facilit		
		4/10, the resident was			and Hospice provider and crea		
	re-admitted to	the facility, to the			an interdisciplinary care plan		
	locked/secured	d Alzheimer's unit, with			Hospice and Facility. Facility		
	diagnoses that	included, but were not			conducted a meeting with the		
ı	limited to, seni				Hospice Provider on 10/18/12	to	
	-Alzheimer's ty				update residents care plan to		
	· ·	/sphagia, severe			address resident's individual		
	, ,	•			needs. Family notified of upda	I .	
	chronic back d	-			to care plan and new orders a	nd	
	· ·	ractures, and pelvic			family agreed with updates.		
	joint pain.				How other residents having	, ho	
					How other residents having to		
	A quarterly M.I	D.S. [Minimum Data			potential to be affected by the same deficient practice will be	I .	
	Set] assessme	ent, dated 7/25/12,			identified and what correctiv		
	_	esident had adequate			action(s) will be taken:	`	
		ar speech, and required					
	i nearing, unde	ai specui, and required					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155505	A. BUILDING B. WING		10/18/2012
			_	EET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	8		70 ROBIN RUN W	
ROBIN F	RUN HEALTH CENT	ΓER		DIANAPOLIS, IN 46268	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAC		DATE
	the physical as	sistance of 1-2 staff for		Care Plan Meetings will conti	•
	all daily care.	The assessment		to be conducted for residents	on
	indicated the re	esident's BIMS [Brief		Hospice. The Care Plan	niaa
		ental Status] score was		Meetings will include the Hos Provider, the Facility and	pice
	"00" [0-7=seve	-		Family/Responsible Party wit	hin
	impairment].			first 21-days of admission to	
	inipanincing.			Hospice program. During the	
	An activity "Int	aroot Curvoy" form		Care Plan Meeting the Care	l l
	1	erest Survey" form,		will be reviewed and coordinate	
		indicated the resident		between Hospice Provider ar	
	•	ofessional secretary,		the Facility. Facility will conti	l l
	liked lunch/dinner outings and			to address specific care need	ls,
	birthday parties; enjoyed arts/crafts			duties, and services to be provided to the hospice resid	ont
	instruction and	cooking		by Facility and Hospice Staff.	l l
	demonstrations	s; had an interest in		by I domity and Hoopice Stans	
		worship services and			
		and enjoyed music-		What measures will be put i	nto
	1	ical, soul/blues, folk,		place or what systemic	
	_			changes will be made to	
	holiday, and bi	g bands.		ensure that the deficient	
				practice does not recur:	
		entry, dated 5/2/12			
		/31/12, addressed a		Care Plan team will meet with	•
	problem of "Re	esident has dementia		Hospice and Family within fir	St
	with aggressive	e behaviors." The		21-days of admission to the Hospice program to discuss	Care
	interventions w	vere listed as: "Talk		Plan needs and services spe	l l
	with resident d	uring care; re-orient		to the hospice resident and	
		eded; provide resident		responsibilities for Facility Sta	aff
		s and reminders as		and Hospice Staff.	
	_	ection; praise resident			
		·		Facility staff will be re-educat	l l
		ney make; encourage		what Hospice responsibilities	
	1	pportive and active in		for the hospice resident and	
		life; put up as much of		the Facility responsibilities ar the hospice resident.	e ior
		things in their room		the hospice resident.	
	such as picture	es; encourage resident			
	to attend activi	ties and socialize with		How the corrective action(s)
	others; encour	age diet/fluids; staff to		will be monitored to ensure	
	·	•			

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SUI	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	ILDING	00	COMPLET	ED
		155505	B. WIN			10/18/20	12
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			OBIN RUN W		
ROBIN R	RUN HEALTH CEN	TER			APOLIS, IN 46268		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE C	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		as resident needs with			deficient practice will not rec	ur,	
	encourage resident to help as much				i.e., what quality assurance	.	
		rovide a safe clutter			program will be put into place:		
	free environme	ent."			A Hospice and Facility role and	d	
					responsibility Quality Assurance	ce	
	Another Care	Plan entry, with no start			Performance Improvement au	dit	
	date listed, add	dressed a problem of			tool will be completed 1 time		
	"Behavioral Sy	mptoms: [Resident's			weekly times 1 quarter, then 1 time bi-weekly for 1-month unt		
	name] has phy	sical behavioral			the alleged deficient practice	."	
	symptoms dire	cted at others." The			does not recur.		
	interventions v	vere listed as: "Provide					
	medication as	ordered; record					
	behaviors on E	Behavior Tracking					
	Form. Monitor	pattern of behavior					
		recipitation factors,					
	1 '	r situations); remind					
		ne] that BEHAVIOR is					
	l -	e; remove from					
		time to calm down."					
		lan entry, with no start					
	date listed, add	dressed a problem of					
	"Behavioral Sy	mptoms: [Resident's					
	name] has oth	er behavioral					
	symptoms not	directed toward					
	others." The in	nterventions were listed					
	as: "Gently re	mind [resident's name]					
	that throwing o	bjects is not					
	appropriate; re	efer to psych					
	[psychiatric] se	ervices as needed.					
		on at times of behavior;					
		dent in a calm manner.					
	1 ' '	y name. Assist with					
		move from situation,					
	allow time to c						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155505	B. WIN			10/18/	2012
NAME OF P	PROVIDER OR SUPPLIEF	}	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					OBIN RUN W		
ROBIN R	RUN HEALTH CENT	ΓER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		10/15/10 1 11 15					
		on 10/15/12 at 11:45					
	A.M., L.P.N. #						
	"Behavior/Intervention Monthly Flow Record" forms as the system used to track the number of episodes of behaviors displayed by a resident.						
	The June July	August and					
	The June, July, August, and September, 2012 forms for Resident						
	1	following targeted					
	behaviors for n						
	Defiaviors for fi	normoning.					
	JuneIncrease	ed anger; tantrum					
		essive behaviors;					
	hitting at staff.	·					
	_	d anger; tantrum					
	1	hosis; hallucinating.					
		ative; verbal abuse;					
	throwing things	S.					
	SeptemberCo	ombative; inappropriate					
	verbal stateme	ents; throwing things.					
		- •					
	The "Interventi	on Codes" key for each					
	month, each ta	argeted behavior, listed					
	the same gene	eral and generic					
	approaches: "	Redirect; 1 on 1; refer					
	to nurse's note	es; activity; return to					
	room; toilet; giv	ve food; give fluids;					
	change positio	n; adjust room					
	temperature; b	ackrub."					
		interventions added					
	that were spec	ific to this resident.					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155505	A. BUII	LDING	00	COMPL: 10/18/	
		130300	B. WIN		PRESIDENCE CONTROL CON	10/10/	2012
NAME OF P	PROVIDER OR SUPPLIER				DBIN RUN W		
ROBIN R	RUN HEALTH CENT	ER			APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION DATE
TAG		y conference on		TAG	BEITEENCTY		DATE
		5 P.M., the Executive					
		e interim Director of					
	Nursing were given the opportunity to						
		cumentation/evidence					
	1	ns, individualized to					
		lent's interests and					
	preferences, w	ere care-planned.					
		on 10/18/12 at 5:05					
	P.M., no addition						
	documentation						
	individualized	•					
	review.	ere provided for					
	review.						
	B 1 In an inte	rview during the initial					
		on 10/15/12 at 11:40					
	A.M., L.P.N. #1	I indicated Resident					
	•	ff-propelled "Broda"					
	[specialized red	clining wheelchair] for					
	mobility, neede	ed physical assistance					
	from staff for a						
		his hands and one					
		ribed a puree diet due					
	•	problems, and had a					
		requiring bed and chair urse indicated the					
	a Hospice age	eceiving services from					
	a i lospice agei	icy.					
	The clinical rec	ord for Resident #63					
		on 10/16/12 at 2:40					
	P.M. Diagnose	es included, but were					
	not limited to, s	senile dementia-					

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Event ID: NQP211

Facility ID: 001156

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/18/2012
	PROVIDER OR SUPPLIE		6370 R	ADDRESS, CITY, STATE, ZIP CODE COBIN RUN W JAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	non-insulin de chronic obstru disease, dysph	rpe, depression, pendent diabetes, ctive pulmonary nagia, and coronary with history of heart			
		vas admitted to a se agency on 4/25/12.			
	Progress Note indicated a quadrated a quadrated a property of the formas attempts of the form as attempts of the formation of	linary Care Plan s" form, dated 8/8/12, arterly Care Plan as held. The facility Director, the Dietary Alzheimer's unit If the unit nurse signed bendees. There were from any Hospice staff. Inote indicated " He eccive Hospice care"			
	Progress Note indicated a Ca held "per famil signatures incl nursing staff indicated " A related to curre health status. having a conceduring meals.	linary Care Plan s" form, dated 9/10/12, re Plan conference was y request." Attendee uded two Hospice A "Comments" note Addressed questions ent health condition and Resident is currently ern with coughing Family does not want a stomy tube for			

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
IND LAN	of conduction	155505	A. BUILDING B. WING		10/18/2012
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEI	R		OBIN RUN W	
ROBIN R	RUN HEALTH CEN	TER	INDIAN	IAPOLIS, IN 46268	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
ing	REGULATORT OF	KEEC IDENTIFIEND IN ORNIZITION)	ing	·	DATE
	The facility Ca	re Plan, with problem			
	start dates of 3/12, 7/9, 8/7, and				
	9/11/12, addre	ssed problem areas of			
	· ·	continence of bladder			
		elf care deficit, altered			
		n, risk for falls, DNR			
	-	citate] status, diabetes			
		y pain, depression and haviors, dementia and			
		s, nutritional status and			
		nd activity deficits. The			
		sted for each problem			
		e provided by facility			
	staff. There w	ere no interventions			
	listed related to	o Hospice			
	· •	and services to be			
	provided by the	at agency.			
	A facility Care	Plan entry, dated 4/25			
	•	/5/12, addressed a			
	-	esident on Hospice."			
	The intervention	ons, to be provided by			
	facility staff, we	ere listed as: "All staff			
		ware of resident being			
	•	aff will keep hospice			
		nformed of the			
		lition and any changes;			
		rage hospice staff to the best way to care for			
		are in need of			
	1	ent than they were			
		to hospice; family will			
	· ·	e that staff will be			
	working with h	ospice and can assist			

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155505	B. WING		10/18/2012
	PROVIDER OR SUPPLIE		6370 F	ADDRESS, CITY, STATE, ZIP CODE ROBIN RUN W NAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
	themselves me how that they assist the resignation of care we and updated at the services to be provided facility and Hollisted. The Hospice at which was lock binder at the services to be Hospice skiller and chaplain. listed as "Deci Alteration in Carminal Condaide Needed; Alteration in Education in Educa	list of specific s, duties, and services to the resident by spice staff was not agency Care Plan, ated in a separate Jurse's Station and 2/25/12, listed the provided by the d nurse, social worker, Problem areas were sional capacity; omfort; Management of dition; Home Health Advance Directives; ardio-Pulmonary ration in Nutritional or Skin Breakdown; rrangements; High Risk Determinations/Dignity; motional Functioning; Concerns. The t would provide the or these entries were			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155505	B. WIN	G		10/18/	2012
NAME OF B	ADOLUDED OD GLIDDLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C .		6370 R	OBIN RUN W		
	UN HEALTH CENT	ΓER		INDIAN	APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		Care Plan entry					
	addressed a problem "Integration of						
	Nursing Home/ALF [Assisted Living						
	Facility] and Ho	ospice POC [Plan of					
	Care]." The interventions were listed						
	as: "Hospice F	Plan of Care will be					
	communicated	to nursing home within					
		plementation; Instruct					
		e with nursing home					
	staff regarding	•					
		related to the Hospice					
	•	staff will attend nursing					
		care meetings to					
	-	nation; Hospice staff					
	_	2-3/ 14 days, HA					
	_	durable medical					
	· •						
		ovided by Hospice:					
	none at this tim	ne."					
	A coordinated	list of specific					
	responsibilities	, duties, and services					
	to be provided	to the resident by each					
	•	nd Hospice disciplines					
	was not listed.						
	On 10/17/12, tl	he Executive Director					
	provided a cop	y of the contract the					
	facility had with	n the Hospice agency					
		ident #63. The					
	,	ed, but was not limited					
	to, the following						
	13, 11.0 10.00	g					
	"Definitions: (i) <u>Plan of Care</u>					
	Hospice and F	acility will jointly					
	develop and a	gree upon a					
	·						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155505	B. WIN		-	10/18/	2012
NAME OF B					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	· ·		6370 R	OBIN RUN W		
ROBIN R	RUN HEALTH CENT	ΓER		INDIAN	APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		terdisciplinary Plan of					
		consistent with the					
	1	ophy and is responsive					
	to the unique needs of Hospice Patient Hospice and Facility shall periodically conduct joint reviews of						
each Plan of Care as necessary to							
	•	vision of Facility					
	Services						
	Responsibilities of Facility. (e)(ii) Design of Plan of Care. In accordance with applicable federal						
		and regulations,					
		pordinate with Hospice					
		a Plan of Care for each					
	Hospice Patier	nt					
	3. Responsibili	ities of Hospice. (ii)					
	Plan of Care.	(b) Provision of Plan of					
	Care to Facility	<u>∠</u> : Upon a Hospice					
	Patient's admis	ssion to Facility,					
	Hospice shall f	furnish a copy of the					
	current Plan of	Care. Hospice shall					
	specify the Fac	cility Services to be					
	furnished by Fa	acility to such Hospice					
	1	Coordination and					
	, , , –	ospice shall retain					
		or coordinating,					
		administering the					
		am, as well as ensuring					
		of care of Hospice					
	Patients, which	·					
	· ·	f Facility Services"					
		cal record review for					
	l						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLI	ETED
		155505	B. WIN			10/18/	2012
			D. 111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			OBIN RUN W		
ROBIN R	UN HEALTH CENT	ΓER			APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Resident #26 v	vas completed on					
	10/16/12 at 1 F	P.M. Diagnoses					
	included, but w	vere not limited to,					
	end-stage dementia, aphasia/dysphagia. Resident #26 had a change in condition on 9/13/12 and was						
		spice on 9/15/12. The					
	facility had a care plan for Hospice.						
		ot indicate who was					
		ces for pain, who was					
		ng assistance, who					
	was providing	ADL assistance and					
	when these se	rvices were to be					
	provided. It als	so did not give any					
	frequency rega	arding how often					
		ed Hospice services.					
	In an interview	during the daily					
	conference on	10/17/12 at 4:15 P.M.,					
	R.N. #10 indica	ated nursing staff had					
		ations with the Hospice					
		were in the building.					
	1	urses for each agency					
	-	by phone as needed.					
		the facility had no					
	•	e assignments for					
	_	r Hospice aides related					
	· ·	d not have a list for					
	scheduled visit	ts.					
	0.4.05(1)(4)						
	3.1-35(b)(1)						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505 NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER			OOOOCADDRESS, CITY, STATE, ZIP CODE ROBIN RUN W	(X3) DATE SURVEY COMPLETED 10/18/2012	
ROBIN F	RUN HEALTH CENT	ER	INDIA	NAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=G	HIGHEST WELL Each resident must provide the services to attain practicable physic psychosocial well the comprehensive care. Based on reconsistering interview, the fracturate nursing completed relabilateral lower ordered medicanot administers (Resident #30) symptoms of in gastrostomy turesulting in delitreatments. The 2 of 2 residents assessments as 15. Findings included the clinical #30 was review 12:45 P.M. Diagnoses for but were not ling thrombocytope pressure, insortions.	ast receive and the facility necessary care and or maintain the highest cal, mental, and libeing, in accordance with we assessment and plan of acility failed to ensure ng assessments were ted to edema to extremities after an ation for edema was ed for five days, and signs and affection at a be site (Resident #40) ays in antibiotic his deficiency affected is reviewed for nursing and care in a sample of the: The cord for Resident wed on 10/16/12 at Resident #30 included, mited to, ania, high blood	F0309	F309 Provide Care/Services highest well being It is the practice of the provid for each resident to receive to necessary care and services attain or maintain the highest practicable physical, mental, psychosocial well-being. What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice: Resident #30 was reassesses 8/16/12 by the physician and new orders received. Physician and family notified on 9/11/12 and family notified on 9/28/12. Resident #40 Physician and Family were notified on 9/27/2 and order for Cipro was initial Resident currently does not be signs or symptoms of infections.	der he to to t and don no sian

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPLI	ETED
		155505		LDING		10/18/2	2012
			B. WIN		ADDRESS OFTW STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
DODING	NUNCUE AL TULOENIA				OBIN RUN W		
KORIN K	RUN HEALTH CENT	IER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	weakness.				How other residents having t		
					potential to be affected by th		
	Nursing notes.	dated 8/09/12 at 4:30			same deficient practice will b		
		I "Lasix 20 mg. PO			identified and what correctiv	е	
	· ·	<u> </u>			action(s) will be taken:		
	(orally), dailyFamily notified."					-41	
	The A	10 Madiantian			Licensed Staff will be re-educated by the Director of Nursing or	nea	
	The August 2012 Medication				designee on the provider's		
		Record (MAR)			policies regarding order		
		(20 mg. (milligrams),			transcription, assessment for		
	one (pill), PO (orally), daily for edema,			edema, assessment for signs	and	
	was ordered by	y the physician on			symptoms of infection,		
	8/09/12. The A	August 2012 MAR			documentation of assessment	S,	
		nedication was not			and notification of next shift ar		
		12, 8/10/12, 8/11/12,			of physician regarding change		
	_				condition. Staff responsible for		
	· ·	/13/12. The first dose			medication administration will	be	
		red on 8/14/12, as			re-educated regarding the		
	indicated on th	e MAR.			provider's policy regarding unavailable medications.		
					unavallable medications.		
	Nursing notes	did not indicate any					
	assessment wa	as completed related to			What measures will be put in	to	
	not receiving L	asix, 8/9 to 8/13/12.		place or what systemic			
	1	view with the DON on			changes will be made to		
		:00 A.M., she indicated			ensure that the deficient		
		six (diuretic), for			practice does not recur:		
		, ,,					
		was chronic lower			A Quality of Care Quality		
	1	na but, no assessments			Assurance Performance		
		vere completed by			Improvement audit tool will be		
	nursing staff.				utilized weekly times 4 weeks, then bi-weekly times 4 weeks,		
					then monthly until alleged		
	Physician note	s, dated 8/16/12,			deficient practice does not rec	ur.	
	1 7	nd +2 edema to the			asilon practice account for		
		es, equal bilaterally.					
					How the corrective action(s)		
	1	s, dated 8/28/12,			will be monitored to ensure t	he	
		x was not given for			deficient practice will not rec		
	several davs a	nd edema became]	•	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155505	A. BUII B. WIN			10/18/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			OBIN RUN W		
DORINI D	UN HEALTH CENT	red			APOLIS, IN 46268		
	ONTILALITICLIVI		_	INDIAN	AI OLIO, III 40200		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	worse (at) one	point."			i.e., what quality assurance		
					program will be put into plac	e:	
	Nursing notes,	dated 9/01/12 at 11:00					
	_	l "Residents bilat			The Quality of Care Quality		
		na has gotten worse,			Assurance Performance Improvement audit tool will be		
		n bed to elevate her			reviewed in the monthly Qualit		
					Assurance Performance	.,	
	_	(complains of) pain in			Improvement meeting by the		
		s are very tight. + (plus			Quality Assurance committee.		
	, , ,	emawill continue to			-		
	monitor her leg	JS"			Deficiency in this practice will		
					result in disciplinary action up		
	On 9/28/12 at	11:00 A.M., nursing			and including termination of th	е	
		d, "Left foot, 2nd			responsible associate.		
		ery redtender- +					
	,	ma whole foot, +3 to					
	l "	•					
		ll to Dr. (physician					
	name) - Keflex	order."					
	Nursing notes,	dated 9/28/12 at 9:40					
	P.M., indicated	I, "Res (resident) is on					
	ATB (antibiotic) for cellulitis at left foot					
	2nd (second) to						
	During an inter	view with the DON on					
		:00 A.M., she indicated					
		•					
	the edema was	s not properly					
	assessed.						
	During an inter	view with Resident #30					
	on 10/18/12 at	2:00 P.M., she					
	indicated she	did not know names of					
		ne received and did not					
		he trusts the nurses to					
	•	dditionally, she said					
	sne ⁻ s "nad pair	nful swelling to her	\perp				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155505	B. WING	G		10/18/	2012
NAME OF P	ROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					OBIN RUN W		
ROBIN R	UN HEALTH CENT	ΓER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	wo, or so, months,					
	''	They (legs) were					
	swollen, tight, a	and painful."					
		al record for Resident					
		ved on 10/15/12 at					
	1:00 P.M.						
	_	Resident #40 included,					
		nited to, osteoporosis,					
	_	eration, high blood					
	'	I fibrillation, chronic					
		ysphagia, history of					
		lar accident with					
	•	ic anxiety, left sided					
	pleural effusior	n, gastroesophageal					
	reflux disorder,	, failure to thrive and					
	S/P (status pos	st) gastrostomy.					
	_	on 9/07/12 indicated,					
		G-tube (gastrostomy					
	,	(dressing) when					
	,	g. (large) amt. (amount)					
	of greenish slir	nmy (sic) odorous					
	drainage noted	 Passed on to day 					
	nurse."						
	_	view with RN #1, on					
		05 P.M., she stated					
	"The communi	cation between the					
	night shift nurs	e and the day shift					
	nurse, on 9/07	/12, was not clear. The					
	day shift nurse	told her (RN #1) he					
	was not aware	of a possible infection					
	around Reside	nt #40's G-tube					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155505	B. WIN			10/18/	2012
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			OBIN RUN W		
ROBIN R	RUN HEALTH CENT	ΓER			APOLIS, IN 46268		
					711 0210, 117 10200		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	,	ube) site, on 9/07/12."					
	RN #1 indicate	ed there was a lack in					
	communication	n between the nurses					
	that resulted in	the physician not					
	being notified of	of a change in					
	condition, thus	resulting in a delay in					
	treatment.	,					
	Physician orde	ers, dated 9/27/12,					
		ntibiotic was ordered,					
		(milligrams), crush					
		· • ·					
	· •	nkle around G-tube					
	site, daily for 7	days.					
		9:45 A.M., nursing					
	notes further in	ndicated, "Res.					
	(resident) is on	ATB (antibiotic) for GI					
	(gastrointestina	al) site infection"					
	Resident #40 r	eceived antibiotic					
	(Cipro) treatme	ent for an infection at					
	' ' '	om 9/28/12 to 10/04/12,					
	·	the September 2012					
	and October 2	•					
	During the dell	v conforces on					
		y conference on					
	· ·	mation related to					
		ments of the area					
		ube was requested.					
	The DON and	RN#1 voiced					
	agreement and	d understanding. As of					
	the exit confere	ence on 10/18/12, this					
		rmation/documentation					
	was not preser						

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PRINTED: 11/21/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 155505	: A.	(2) MULTIPLE CO . BUILDING . WING	NSTRUCTION 00	(X3) DATE COMPI 10/18	LETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCII (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE			
	3.1-37(a)		-						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/18/2012		
	ROVIDER OR SUPPLIER UN HEALTH CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
F0312 SS=D	RESIDENTS A resident who is activities of daily inecessary service nutrition, groomin hygiene. Based on obse and interview, the ensure staff we given by speed regards to cuein residents obserteding during the main dining 15. (Resident #13 who 10/17/12 at 3:1 included, but who blindness, anxious disease. A physician's or indicated speed with resident the fourteen days the penetration/aspleast restrictive.	e: ord review for vas completed on 5 P.M. Diagnoses ere not limited to, legal ety, and reflux rder dated 7/18/12, ch therapy was to work iree times a week for o rule out biration, and determine	F03	12	F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENT It is the practice of the provide ensure residents who are una to carry out activities of daily livereceive the necessary service maintain good nutrition, grooming, and personal and on hygiene. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #13 was seen by Speech language pathologist 11/8/12 and recommendations level of assistance needed at meal times and appropriate dishas been updated. How other residents having a potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	er to ble iving s to oral on s for et the ne pe	11/17/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURV	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETEI	
		155505	B. WIN	G		10/18/201	2
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SOTT EIEF			6370 R	OBIN RUN W		
ROBIN R	UN HEALTH CENT	ΓER		INDIAN	IAPOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	MPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	intermittent s/s (signs			Facility will review resident's quarterly Speech Therapy		
	and symptoms				screenings for residents that		
		swallowing) as			need assistance with cueing a	nd	
	reported by nu				meal consumption to monitor t		
		eight lossNew dx			the facility is following Speech		
	, • <i>,</i>	_ (left lower lobe)			Therapy's recommendations.		
	•	ontinued wt (weight)					
		ent (line through			What measures will be put in	to	
	, ·	onia" The speech			place or what systemic		
	therapy notes				changes will be made to		
	indicated, "lit				ensure that the deficient		
		much encouragement			practice does not recur:		
	and some feed	ling per staff" The					
		y discharge notes for			Licensed nurses and aides we	re	
	8/1/12 indicate	d, "Caregivers will			re-educated on cueing and		
	return demo (d	emonstration)			encouraging residents to		
	understanding	of pt spec.(specific)			consume meals.		
	safe swallow to	echniques (sign for			Recommendations for level of assistance needed at meal time		
	with) 90 (sign f	or percent) acc			and appropriate diet will be		
	(accuracy)giv	ven tactile/verbal			updated in CareTracker profile	for	
	cueing from ca	regivers"			the residents that need help w		
					assistance with cueing and me	eal	
	A meal observa	ation was done on			consumption.		
	10/15/12 at 1:2	20 P.M. in the main					
	dining room. T	here was a group of			How the corrective action(s)		
	residents sitting	g at a table. CNA #3			will be monitored to ensure t	_	
	was observed	standing over Resident			deficient practice will not rec	ur,	
	#13. She stab	bed the grilled cheese			i.e., what quality assurance		
	sandwich with	a fork and gave the			program will be put into plac	e:	
	sandwich to Re	esident #13. CNA #3					
	also gave piec	es of brownie to the			A resident meal cueing Quality	,	
		time did she cue or			Assurance Performance		
	encourage the	resident to eat.			Improvement audit tool will be		
	_				utilized weekly times 4 weeks, then bi-weekly times 4 weeks,		
	In an interview	with Speech Therapist			then monthly until the alleged		
		· '			1 , , , , , , , , , , , , , , , ,		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	COMPLE		
THE TENNY	or conduction	155505	A. BUILDING		10/18/2	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8		OBIN RUN W	•	
	UN HEALTH CENT			IAPOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRI DEFICIENCY)	OPRIATE	COMPLETION DATE
1710		2 at 5:00 P.M. she	1710	deficient practice does not		DITTE
		taff had been trained		·		
		nniques for Resident		The Quality Assurance	4 adit	
	#13.	•	Performance Improvement audit tools will be reviewed in the			
				monthly Quality Assurance	e	
	3.1-38(a)(2)(D)			Performance Improvemen		
				meeting by the Quality As committee.	Surance	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155505	B. WIN	G		10/18/	2012
	PROVIDER OR SUPPLIER			6370 R	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0314 SS=D	483.25(c) TREATMENT/SV PRESSURE SOF Based on the con a resident, the face resident who enter pressure sores do sores unless the condition demons unavoidable; and sores receives no services to promo infection and preventive of the face developing. Based on recon interview, the face adequate prevential pressure areas resident with a pressure areas residents revier in a sample of Findings include The clinical recon Resident #4 wa 10/17/12 at 10 included, but wa Alzheimers, with disturbance, ar The 10/2/12 Qu (Minimum Data resident was his impaired, need	CS TO PREVENT/HEAL RES Inprehensive assessment of cility must ensure that a gers the facility without the pes not develop pressure individual's clinical strates that they were a resident having pressure recessary treatment and one healing, prevent went new sores from a red review and facility failed to provide rention measures to a history of healed on the feet for 1 of 5 wed for pressure areas 15. (Resident #4) The resident material individual is completed on the feet for 1 of 5 wed for pressure areas 15. (Resident #4) The resident material is completed on the feet for 1 of 5 wed for pressure areas 15. (Resident #4) The resident material is completed on the feet for 1 of 5 wed for pressure areas 15. (Resident material is completed on the feet for 1 of 5 wed for pressure areas 15. (Resident material is completed on the feet for 1 of 5 wed for pressure areas 15. (Resident material is completed on the feet for 1 of 5 wed for pressure areas 15. (Resident material is completed on the feet for 1 of 5 wed for pressure areas 15. (Resident material is completed on the feet for 1 of 5 wed for pressure areas 15. (Resident material is completed on the feet for 1 of 5 wed for pressure areas 15. (Resident material is completed on the feet for 1 of 5 wed for pressure areas 15. (Resident material is completed on the feet for 1 of 5 wed for pressure areas 15. (Resident material is completed on the feet for 1 of 5 wed for pressure areas 15. (Resident material is completed on 1 of 1	F03		F314 Treatment/Services to Prevent/Heal Pressure Sores It is the practice of this provide ensure a resident who enters of facility without pressure sores does not develop pressure sor unless the individual's clinical condition demonstrates that the were unavoidable. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #4 is presently on a lair-loss mattress and has Pode boots to bilateral lower extremities. The wounds that were located on the resident's bilateral heels have healed. How other residents having the potential to be affected by the same deficient practice will be same deficient practice.	er to che es ey l ow us	11/17/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	155505	A. BUII B. WIN	LDING	00	10/18/2	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	PROVIDENCE NA LA CORRESPONDO		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	AIL	DATE
	Resident #4 was clinic on 2/22/1 fluid filled blisted wound progress wound was a standard the wound recommended care clinic notes the resident's resident'	as sent to wound care 2 due to having a clear er on his right heel. The is notes indicated the stage II and was 3.6 x atment was started care nurse a boot. The wound es for 3/13/12 indicated ight heel had healed. ation did not indicate ntion measures were after the right heel area is/12. As of 3/13/12 re intact without any orders indicated, on oly prevalon boot to times. I 5/25/12 indicated on Bilateral Feet at all except) shower and for change)." A ian's order indicated d heels off in bed. A ler dated 9/24/12 e a LAL (low air loss) ted 5/7/12 indicated ofts on bilateral feet			identified and what correctivaction(s) will be taken: Licensed staff were re-educa on requesting preventative measures for residents at risk skin integrity issues. Skin assessments of residents will addressed during Nutrition at meetings weekly. What measures will be put i place or what systemic changes will be made to ensure that the deficient practice does not recur: Licensed staff were re-educa on requesting preventative measures for residents at risk skin integrity issues. Skin assessments of residents are completed weekly by licensed nurses. At risk residents will addressed during Nutrition at meetings weekly. Director of Nursing or designed will audit the Treatment Administration Record daily to 4 weeks, then 3 times per weekly for one quarter until the allegate deficiency does not recur. How the corrective action(sing will be monitored to ensure deficient practice will not reive., what quality assurance program will be put into plant.	ted c for d be risk nto ted c for d be risk ee d be risk ee imes eek eed	
	when in wheel	chairAssess heels			Program will be put litto pla		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIF	PLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DINK	7	00	COMPL	ETED
		155505	A. BUILDING B. WING	J		10/18/	/2012
			_	REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			OBIN RUN W		
ROBIN F	RUN HEALTH CEN	ITER			APOLIS, IN 46268		
	1						
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TA	G			DATE
		avoid further breakdown.			A Treatment Administration		
		n was discontinued as of			Record Quality Assurance Performance Improvement au	dit	
	7/10/12. A car	re plan dated 8/23/12			tool will be completed daily tin		
	indicated inter	rventions were: Monitor			4-weeks, then 3 times per week		
	with skin care	Report to md any			for one quarter until the allege		
	alteration in sl	kin such as rash,			deficient practice does not rec		
	persitant redn	ess or skin			The results of the audits will b	е	
	•	open areasTurn and			reviewed by the Quality		
		ery 2 hrs (hours) weekly			Assurance Performance Improvement Team during the	2	
	· ·	ent, pressure relieving			monthly meeting.	•	
		I and chair. An update			e.i.i.yeeii.ig.		
		9/25/12 to include LAL					
		Multi podus boots when					
	in bed. There						
		erventions listed around					
		both areas had healed					
	_	ne resident had					
	pressure ulce	rs on both feet on					
	9/24/12.						
	A document ti	tled 'wound evaluation					
	flow sheet ind	icated the following					
		garding pressure areas					
	on Resident #	0 0 1					
	5/6/12 · right k	neel -6.4 x 4.2 x .4					
		current prevention					
	_	•					
		were : podus boot					
		eel-5.2 x 2.4 x 0					
	_	The current prevention					
		were : podus boot.					
		ight heel area had					
	resolved						
	7/26/12 the le	ft heel area had					
	resolved						

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	PROVIDER OR SUPPLIE		6370 F	ADDRESS, CITY, STATE, ZIP CODE ROBIN RUN W NAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	1.2 x 0. The cuinterventions v (low air loss m 9/24/12 : right x 0.1. The curinterventions v (low air loss m 10/11/12 : right current prevent podus boot, I mattress and h 10/11/12 : left The current privere : podus to mattress and h A request was 3:30 P.M. regar prevention me resident #4.	heel: 1.8 x 1.6 x 0. evention interventions boot, LAL (low air loss neels off) made on 10/16/12 at arding pressure asures regarding with RN #13 at the ce on 10/18/12 at 5 ated this was all the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		00			r í	X3) DATE SURVEY COMPLETED	
		155505	A. BUII			10/18/2	
		l	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			OBIN RUN W		
	UN HEALTH CENT	ER			APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	ΓE	COMPLETION
F0323	483.25(h)	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
SS=E	FREE OF ACCID HAZARDS/SUPE The facility must of environment remain hazards as is pos receives adequat assistance device	ERVISION/DEVICES ensure that the resident ains as free of accident ssible; and each resident e supervision and es to prevent accidents.	F02	22			11/17/2012
		ervation, interview, and	F03	23	F323 Free of Accident		11/17/2012
	-	the failed failed to			Hazards/Supervision/Devices	•	
		als in 1 of 1 locked			It is the practice of this provide	er to	
		This deficient practice ial to affect 14 of 22			ensure that the resident		
	•	ified as ambulatory			environment remains as free o		
	without assista	•			accident hazards as is possible and each resident receives	ε,	
	without assista	nice.			adequate supervision and		
	Findings includ	le:			assistance devices to prevent accidents.		
	On 10/16/12 at	9:15 A.M., 3 Purell					
		wall dispensers were			What corrective action(s) will	i	
	observed in the	e locked dementia unit.			be accomplished for those residents found to have been	1	
	The 2 wall disp	ensers were located			affected by the deficient		
	-	ween resident rooms.			practice:		
	The other wall	dispenser was located			The residents of Clare Bridget		
	inside the locke	ed dementia unit, near			Dementia Unit had 14 of 22		
	the front entrar	nce where photo			residents that were ambulatory without assistance and were	/	
	albums were k	ept for resident use.			identified as having the potenti	ial	
					to be affected by the alleged		
	All 3 hand sani	tizer wall dispensers			deficient practice. The three		
		g order filled with hand			hand sanitizer dispensers were immediately removed and are		
		wall dispensers were			longer in the Clare Bridge	110	
		el the average size			Dementia Unit.		
	person could reach while standing or						
	ın a sitting posi	ition in a wheelchair.			How other residents having 4	ho	
					How other residents having to potential to be affected by the		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED	
		155505	B. WIN			10/18/	2012	
NAME OF I	DOLUBER OR GURRU IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF E	PROVIDER OR SUPPLIER	C		6370 R	OBIN RUN W			
	RUN HEALTH CENT	ΓER		INDIAN	APOLIS, IN 46268			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE	
		t 9:20 A.M., in an			same deficient practice will be identified and what corrective			
	, ·	Memory Care Facilitator			action(s) will be taken:			
		and sanitizer wall			dotton(o) will be taken:			
	dispenser were	e for the residents' use.			The three hand sanitizer			
					dispensers were immediately			
		t 2:00 P.M., the			removed and are no longer			
		ctor indicated the hand			located on the Clare Bridge Dementia Unit.			
		lispensers were			Dementia onit.			
	removed for th	e safety of the						
	residents.							
					What measures will be put in	ito		
	On 10/17/12 a	t 10:00 AM., the			place or what systemic			
		ctor provided an			changes will be made to ensure that the deficient			
	"MSDS [Mater	ial Safety Data Sheet]"			practice does not recur:			
	for the hand sa	anitizer.			practice account recarr			
					The Alice of the second			
		luded, but was not			The three hand sanitizers were removed from the walls in the	е		
	· ·	duct Name: Purell			Clare Bridge Dementia Unit.	Γhis		
		Sanitizer Hazards			was accomplished immediatel			
		When used according			when the issue was brought to)		
		he product applicable			the provider's attention by the			
		s safe and presents no			surveyors.			
		ong-term health						
		ver, abnormal entry			How the corrective action(s)			
		s gross ingestion, may			will be monitored to ensure t	he		
	require immed	iate medical			deficient practice will not rec	ur,		
	attention"				i.e., what quality assurance			
					program will be put into plac	e:		
	3.1-45(a)(1)							
					Staff will be re-educated to the	,		
					location of the hand sanitizer			
					dispensers and to the reasons	;		
					why the dispensers were removed so that the alleged			
					deficient practice does not rec	ur		
					denoient praedec aces not rec	u		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		0	00	COMPLI	ETED
		155505	A. BUILDI	NG _		10/18/	2012
			B. WING	TENEET A DOI	DEGG CITY CTATE 7ID CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			RESS, CITY, STATE, ZIP CODE		
DODIN F	NINITE AL TIL OFNI	TED		6370 ROBII			
KOBIN F	RUN HEALTH CEN	IER	[I	NDIANAPO	OLIS, IN 46268		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	I	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
F0327 SS=D	483.25(j) SUFFICIENT FL HYDRATION The facility must sufficient fluid in hydration and he Based on obse and interview, monitor the fluid potential dehy resident review sample of 15. Findings included the resident #26 of 10/16/12 at 1 included, but wend-stage deniaphasia/dysph	provide each resident with take to maintain proper ealth. ervation, record review, the facility failed to aid intake to prevent dration for 1 of 1 wed for dehydration in a (Resident #26) de: cord review for was completed on P.M. Diagnoses were not limited to, mentia, magia. otes dated 2/27/12 resident had aspiration on pudding thickened otes dated 8/9/12 resident was at high risk in. dated 8/29/12 indicated ad diuretic use with a ehydration and to offer	F0327	F3 Hy It i en su pro Wi be res aff pr. Re ad de no Ho res de will Ho po sa ide ac Lic re-	BEFICIENCY) B27 Sufficient Fluid Maintain ydration is the practice of the provide insure each resident has ufficient fluid intake to mainta roper hydration and health. That corrective action(s) will be accomplished for those residents found to have been fected by the deficient ractice: The session of the provide insured in the session of the ses	n r to in tor e e e e e	11/17/2012
	potential for de and encourage contraindicate	ehydration and to offer e fluids and foods if not		Lid re- no req Re	censed nurses were		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	COMPLETED	
		155505	B. WIN			10/18/	2012	
			D. WII		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	OBIN RUN W			
ROBIN F	RUN HEALTH CEN ⁻	ΓER			APOLIS, IN 46268			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		room secondary to			addressed quarterly and as			
	'not right'-no a	ppetite -responsive to			needed or upon significant change by the Quality Assurar	200		
	staff-eyes fixed	d pupils-not following			Performance Improvement	ice		
	movement-non-reflexive-somelent				Team. Physician will be			
	(sic)-no change while in Dining				contacted for further interventi	ons		
	` '	oped eating-food feel			as needed.			
	out of mouth-normally eats 100%."							
		otice to the hospital						
		•			What measures will be put in	to		
	indicated the resident was on honey thickened liquids. The resident went				place or what systemic			
to the hospital and returned with				changes will be made to ensure that the deficient				
	orders to receive hospice assistance.				practice does not recur:			
					practice acces not recar.			
		al anadan wallan want dan 4			4Licensed nurses were			
	•	d seeing the resident			re-educated on assessment,			
	on 9/15/12.				notification and documentation	1		
					regarding hydration status.			
	The nurses no	tes indicated the			Residents at risk for impaired hydration status are reviewed	and		
	daughter reque	ested IV fluids on			addressed weekly by the Qual			
	9/15/12. A poi	t a cath was inserted			Assurance Performance	ıty		
	on 9/16/12.				Improvement Team and			
					physician will be contacted for			
	The physician'	s orders indicated on			further interventions as neede	d.		
		continue the diuretic.						
		9/16/12 indicated to			How the corrective action(s)	la a		
		us fluids of D5 1/2 NS			will be monitored to ensure t			
	500 ml x 1 ove				deficient practice will not rec i.e., what quality assurance	ur,		
	500 1111 X 1 000	L Z-7 HOUIS.			program will be put into plac	e:		
	In an observet	ion on 10/16/12 at 1:30			F S. a so bat into blac			
		ng thickened liquids			A hydration Quality Assurance			
	were on the table after the resident was done with the meal. There was a 240 milliliter (ml) glass of thickened				Performance Improvement au			
					tool will be completed on at ris			
					residents for dehydration weel times 4-weeks, then 3 times p	•		
	•	d an 240 ml glass of			week times one quarter until the			
	red thickened	liquid. Both glasses had			alleged deficient practice does			
	approximately	80 ml gone. At 1: 50			not recur. The results of the			

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
		155505	B. WIN	G		10/18/	2012
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					OBIN RUN W		
KORIN K	UN HEALTH CENT	ER		INDIAN	IAPOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	·		DATE
		ent was observed in			Quality Assurance Performand Improvement audits will be	æ	
	•	closed. The resident	reported to the Quality Assurance			nce	
		up at her bedside table			Performance Improvement		
	that had no stra	aw and was full.			Team.		
	In an ohservati	on on 10/17/12 at					
		re was a 240 ml					
		with red thickened					
		e bedside table next to					
	the resident. T						
		140 ml left in cup. At					
		the resident had					
		eal, on the dining room					
		e resident sits, there					
		lass of red pudding					
	_	d and a 240 ml glass of					
	•	hickened liquid. The					
		ad plastic wrap on					
	_	late 10/17/12 was					
	written on the p	plastic. The resident					
	·	in her room at 2:05					
		h eyes closed. The					
		bedside table and					
	•	was gone. RNA					
	(restorative nui	•					
	,	vasn't sure what type of					
		ent was on. She					
	picked up the c	cup and looked into it					
	and stated it m	ust be nectar					
	thickened liquid	ds. She then asked					
	CNA (certified	nursing aide) #11 who					
	said she thoug	ht Resident #26 was					
	on nectar thick	ened. The aides					
	talked amongs	t themselves and then					
	CNA #7 indicat	ed that the resident					
					I		

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		155505	B. WIN	G		10/18/	2012
NAME OF F	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					OBIN RUN W		
ROBIN R	UN HEALTH CENT	ER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	was on honey	thickened liquids.					
		with RN #13 on					
		0 P.M. she indicated					
	the resident wa						
	·	ds and that typically					
	residents with t	thickened liquids do not					
	have fluids at t	he bedside. She					
	indicated RNA	#12 is a restorative aid					
	and may not kr	now the type of fluids					
	the resident is	on. She indicated CNA					
	#7 should knov	v as she assists in					
	feeding Reside	ent #26. She stated the					
	KIOSK where t	he CNA's document					
	have the inform	nation pertaining to the					
	type of fluids th	ne resident is on. She					
		here the CNA/RNA's					
	would get infor	mation for their					
	_	d anything pertaining					
	to care for resid						
	CareTracker. I	RN #13 could not					
	identify how the	e cup got at the					
	•	knows her staff date					
	all the cups and						
	•	indicated the hospice					
		care but was not sure if					
	she gave any f						
	Jan 2 2007 1						
	In an interview	with RN #13 on					
		60 P.M. she indicated					
		dentify who had given					
		ids at the bedside and					
		ot been tracking the					
	1	f fluids for Resident					
	·	in the CareTracker.					
	"20 dritti today	the Care Hacker.					

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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		A. BUILDING B. WING	00	COMP	COMPLETED 10/18/2012			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE			
	3.1-46(b)								

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		155505				10/18/2012	
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DODIN D	LINI LIEAL TULOENT	TED			OBIN RUN W		
ROBIN R	UN HEALTH CENT	ER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0333 SS=G	483.25(m)(2) RESIDENTS FREE ERRORS The facility must of free of any signific Based on record interview, the farmedications we ordered, by the increased, paint resident's bilated This deficiency resident review errors in a same #30) Findings included The clinical record was reviewed to P.M. Diagnoses for I but were not limit thrombocytope pressure, insort degeneration, of weakness. Nursing notes, P.M., indicated (orally), daily, keep and significant to the control of the clinical record in the clinical record was reviewed to P.M.	ensure that residents are cant medication errors. In review and acility failed to ensure ere administered, as a physician, resulting in offul edema to the eral lower extremities. In affected 1 of 1 and for medication exple of 15. (Resident etc.) From 10/16/12 at 12:45 Resident #30 included, mited to, mia, high blood enia, macular dysphagia, and muscle etc. Idea (100 of 10/16/12 at 4:30 etc.) In a control of 10/16/12 at 4:30 etc. In a cont	F03		F333 Residents Free Of Significant Med Errors It is the practice of the provide ensure the residents are free of any significant medication error. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #30 has received the ordered Lasix. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Licensed staff were re-educated on order transcription, assessment, documentation and notification by the Director of Nursing or designee. Staff responsible for medication administration will be re-educated regarding the provider's policy regarding missed medications.	of ors. I I I I I I I I I I I I I I I I I I I	11/17/2012
	The August 20	12 Medication			What measures will be put in	to	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	TED
		155505	B. WIN			10/18/2	2012
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	2			OBIN RUN W		
ROBIN R	UN HEALTH CENT	ΓER			APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Administration	Record (MAR)			place or what systemic		
	indicated Lasix	20 mg. (milligrams),			changes will be made to		
		orally), daily for edema,		ensure that the deficient			
	was ordered by the physician on		practice does not recur:	practice does not recur:			
	•				A Missing Madisotion Ovelity		
	8/09/12. The August 2012 MAR indicated the medication was not				A Missing Medication Quality Assurance Performance		
					Improvement audit tool will be		
	_	12, 8/10/12, 8/11/12,			utilized weekly times 4 weeks,		
	•	/13/12. The first dose			then bi-weekly times 4 weeks,		
		red on 8/14/12, as			then monthly until the alleged		
	indicated on th	e MAR.			deficient practice does not rec	ur.	
	The August 20	12 MAR indicated K Cl,					
	•						
	•	vas ordered by the			How the corrective action(s)		
		/09/12. The August			will be monitored to ensure t	he	
		cated the medication			deficient practice will not rec	ur,	
	_	on 8/09/12, 8/10/12,		i.e., what quality assurance			
	8/11/12, 8/12/1	2, and 8/13/12. The			program will be put into plac	e:	
	first dose was	administered on					
	8/14/12, as ind	icated on the MAR.			A Missing Medication Quality		
					Assurance Performance		
	Physician note	s, dated 8/16/12,			Improvement audit tool will be		
		nd +2 edema to the			reviewed in the monthly Qualit		
		es, equal bilaterally.			Assurance Performance		
		s, dated 8/28/12,			Improvement meeting by the		
		x was not given for			Quality Assurance Team.		
		nd edema became			Re-education and corrective action will be provided as		
	•				indicated by the audit tool		
	worse (at) one	point.			findings.		
	During an inter	view with RN#1 on					
	_	80 P.M., she indicated					
		e that the Lasix was not					
	_	d the medication nurse					
		ne order for Lasix and					
	an incident rep	ort was completed.					

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	OF CORRECTION IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/18/2012
	PROVIDER OR SUPPLIER RUN HEALTH CENTER	6370 R	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	A facility incident report, dated 9/06/12, provided by the Administrator on 10/18/12 at 9:00 A.M., included, but was not limited to, the following: "Lasix 20 mg and K CI 8 mEq was ordered daily on 8/9/2012. On 8/14/2012 Medication nurse that day noted that the medications had not been given. Medications were written on the MAR, however, no times to be given were noted on the MAR. Spoke with Nurse who had passed the meds (medications) to that resident on 8/10 - 8/13 as to why meds were not given. That nurse stated I must have overlooked them." A document titled "Weekly Skin Integrity Review," with an entry dated 9/01/12, indicated "edema bilat (bilateral) legs." On 9/28/12 at 11:00 A.M., nursing notes indicated, "Left foot, 2nd (second) toe very redtender- + (plus sign) edema whole foot, +3 to +4 edema- call to Dr. (physician name) - Keflex order." Nursing notes, dated 9/28/12 at 9:40 P.M., indicated, "Res (resident) is on ATB (antibiotic) for cellulitis at left foot 2nd (second) toe"			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		A. BUILDING B. WING			COMPLETED 10/18/2012	
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	During an interview with Resident #30 on 10/18/12 at 2:00 P.M., she indicated she did not know names of medications she received and did not ask because she trusts the nurses to do their job. Additionally, she said she's "had painful swelling to her lower legs for two, or so, months, approximately. They (legs) were swollen, tight, and painful." 3.1-48(c)(2)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00		
		155505	B. WIN			10/18/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ROBIN R	UN HEALTH CENT	ER	INDIANAPOLIS, IN 46268		OBIN RUN W APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0371 SS=F	483.35(i) FOOD PROCURI STORE/PREPAR The facility must - (1) Procure food of considered satisfallocal authorities; (2) Store, prepare under sanitary co Based on observed review, properly store of failed to ensure pans and bowle practice had the residents who of prepared in 1 of Findings include On 10/15/12 at kitchen was initial Dining. 1. At that time, observed in the The following if the shelves of the A. 1 open bag without an ope	E, RE/SERVE - SANITARY from sources approved or actory by Federal, State or and e, distribute and serve food nditions ervation, interview, and the facility failed to and handle food and e proper drying of metal s. This deficient e potential to affect 74 consume food of 1 facility kitchen.	F03		F371 Food Procure, Store/Prepare/Serve-Sanitary is the practice of the provider to procure food from approved sources by Federal, State or Local authorities and store, prepare, distribute and serve frunder sanitary conditions. Who corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The food product in question was either discarded the food was covered, labeled and dated. The pots and pan were washed again and sanitize and placed appropriately on the shelves to allow for air drying. How other residents having the potential to be affected by the same deficient practice where identified and what corrective action(s) will be taken: The food product in question was either discarded the food was covered, labeled and dated. The pots and pans were washed again and sanitize and placed appropriately on the same washed again and sanitize and placed appropriately on the same washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitize and placed appropriately on the store washed again and sanitized the store washed again and sanitized the store washed	ood nat n or s zed ne y vill or s zed	11/17/2012
	a secure seal.				shelves to allow for air drying. What measures will be put		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	DING	00	COMPL	ETED
		155505	A. BUII B. WIN	LDING		10/18/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			OBIN RUN W		
		TED					
KUDIN K	UN HEALTH CENT	IER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	C. 1 tray with	10 custard pies without			into place or what systemic		
	a preparation of	or use-by date, open to			changes will be made to		
	air.				ensure that the deficient		
					practice does not recur: The	Э	
	D 1 tray with	10 brownie squares			Dining Services staff will be		
	D. 1 tray with 10 brownie squares with whip cream on the side without a				educated on proper product storage to ensure the food		
	•	use-by date, open to			products are covered, labeled		
		use-by date, open to			and dated appropriately. In	,	
	air.				addition, the Dining Services s	staff	
					will be educated on proper		
	_	7 cherry turnovers			handling of pots and pans afte		
	without a preparation or use-by date				washing to ensure the pots an		
	and 1 of 7 ope	n to air.			pans air dry properly before be	eing	
					used again. How the		
	F. 1 plastic co	ntainer with 17			corrective action(s) will be monitored to ensure the		
	raspberry scon				deficient practice will not rec		
	preparation or				i.e., what quality assurance	ui,	
	proparation of	doe by date.			program will be put into plac	e:	
	G 2 loaves of	banana bread without			A food storage and dish air d		
					Quality Assurance Performand		
	a preparation of	or use-by date.			Improvement audit tool will be		
					completed by the Director of		
	_	vI of chopped celery			Dining Services or designee 2		
	without a prepa	aration or use-by date.			times daily times 1 quarter, the		
					daily times 1 month, then wee until the alleged deficient prac	•	
	I. 1 open bag	of grated parmesan			does not recur.	uce	
	cheese without	t a use-by or open			acco not recar.		
	date.						
	J. An open ga	llon container of					
		ut a use-by or open					
	date.	at a doo by or opon					
	uale.						
	IZ An an an analysis of the College						
		Illon container of relish					
	without a use-b	by or open date.					
	I Δ 32 ομησα	iar of capers without a					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 18/2012
	PROVIDER OR SUPPLIER		STREET A 6370 RG	ADDRESS, CITY, STATE, ZIP CO OBIN RUN W APOLIS, IN 46268	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	M. An open gause-by or oper	allon of salsa without a				
	1	tems were observed on g cart that was open to				
l		green bean salad paration or use-by date.				
	O. 1 pan of marinated mushroom salad without a preparation or use-by date.					
	P. 1 pan of sp a preparation of	ring salad mix without or use-by date.				
	Q. 1 pan of sh a preparation of	redded lettuce without or use-by date.				
	1	tems were located in rigerator inside a closed				
	pureed [Directe	8 bowls of green or of Dining unable to at a preparation or and open to air.				
	1	12 plates of use per tray without a use-by date and open				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 00	COMI	E SURVEY PLETED 8/2012	
	PROVIDER OR SUPPLIE		STRE 637	EET ADDRESS, CITY, STATE, 2 0 ROBIN RUN W IANAPOLIS, IN 46268	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	per tray without use-by date and On 10/15/12 at interview, the indicated she needed to be however, regard observed uncovered door. On 10/16/12 at Executive Dires "Labeling" policy and bated 10/15/15. The policy and but was not limit food items must have a lad date prepared discard All respondent was on the stored on some containers will or film wrap on name and date.	of 11:00 A.M., in an Director of Dining knew the above items labeled and covered; arding the dessert items overed in the rolling ght those items could since the cart had a since the labeled and dated All prepared items abel with name of item, by whom and dates of defrigerated items must shelving Food storage she: with tight-fitting lider foil labeled with				
		e metal pans and metal				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(2	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		COMPLETED
		155505	B. WING		_	10/18/2012
NAME OF F	ROVIDER OR SUPPLIEF	3	STRE	ET ADDRESS, CITY, STATE, ZII	P CODE	
TWINE OF T	NO VIDEN ON BOTTELET	•		ROBIN RUN W		
ROBIN R	UN HEALTH CENT	ΓER	INDI	ANAPOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE HE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DEFICIENCY)	
	bowls were observed stacked					
together. Water was observed						
	between each pan and bowl.					
	At that time, in an interview, the					
	Director of Din	ing indicated she was				
	aware that whi	le drying, nothing				
should be stacked.						
	On 10/16/12 at	t 9:00 A.M., the				
Executive Director provided "Washing and Sanitizing Dishes" policy and procedure, dated 10/15/12.						
	The policy and	procedure included,				
	but was not lim	nited to, "Pots, pans,				
		ensils must be washed				
	_	using appropriate				
		ng procedures Allow				
		on a sanitized drain				
	board"					
	355.0					
	3.1-21(i)(3)					
	(-/(-/					

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Event ID: NQP211

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155505				10/18/	2012
			B. WIN		ADDRESS SITU STATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
DODIN D		TED			OBIN RUN W		
KORIN K	RUN HEALTH CEN	IER		INDIAN	IAPOLIS, IN 46268		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	· ·			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0372	483.35(i)(3)						
SS=C	DISPOSE GARE	BAGE & REFUSE					
	PROPERLY						
		dispose of garbage and					
	refuse properly.						
	Based on obse	ervation and interview,	F03	72	F372 Dispose Garbage and		11/17/2012
	the facility faile	ed to ensure the facility			Refuse Properly It is the		
	garbage storage area was free of				practice of this provider to		
	-	ent the potential			dispose of garbage and refuse	9	
		•			properly What corrective	_	
harborage and feeding of pests on the ground of 1 of 1 dumpster area. This deficient practice affected 74 of				action(s) will be accomplished	ed		
				for those residents found to			
				have been affected by the			
	74 residents w	who resided in the			deficient practice: The allege	ed	
	facility.				deficient practice had the potential to affect 74 residents		
					and the debris was immediate		
	Findings inclu	de:			cleaned when it was brought t	•	
					the communities' attention by		
	On 10/16/12 a	at 2:00 P M			surveyors. How other reside		
		tour of the facility was			having the potential to be		
		-			affected by the same deficien	nt	
		he Executive Director,			practice will be identified and		
		ice Director, and the			what corrective action(s) wil		
	Housekeeping	Director.			be taken: The alleged deficie		
					practice had the potential to a		
	At that time, th	ne facility waste area			74 residents and the debris wa	as	
	was observed	•			immediately cleaned when it w	vas	
		•			brought to the communities'		
	The facility ha	d a compact area for			attention by the surveyors. WI		
		<u>.</u>			measures will be put into pla		
		nd 1 dumpster located			or what systemic changes w	ill	
	outside the fac	cility.			be made to ensure that the		
					deficient practice does not		
	In an interview	v, at that time, the			recur: Staff will be re-educate		
	Executive Dire	ector indicated the			on proper garbage removal ar		
outside dumpster was only used for				keeping the trash dumpster ar clean and free of debris. Ho			
	recycled paper. However, on the				the corrective action(s) will be		
	1				monitored to ensure the	,	
	•	d the dumpster, the			deficient practice will not rec	· iir	
I	ı tollowina debr	is was observed and	1		actionerit practice will not let	·ui,	

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/18/2012
	PROVIDER OR SUPPLIER	6370 R	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W IAPOLIS, IN 46268	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	included, but was not limited to, a beer aluminum can, a "V 8 [vegetable drink]" aluminum can, aluminum foil, a plastic fork, stained napkins and a large amount of paper debris [newspaper] all around the dumpster and between the dumpster and building. On 10/17/12 at 9:30 A.M., in an interview, the Executive Director indicated the facility cleaned the area around the dumpster. 3.1-21(i)(5)		i.e., what quality assurance program will be put into place. A trash dumpster debris Quarassurance Performance Improvement audit tool will be completed by the Director of Housekeeping or designee 1 to daily time 1 quarter, then wee time 1 quarter until the alleged deficient practice does not recommend.	e ime kly

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPL	ETED
		155505	B. WIN			10/18/	2012
NAME OF P	ROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
ROBIN R	UN HEALTH CENT	ER			OBIN RUN W IAPOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		DEFICIENCY)	IE	DATE
	483.60(c) DRUG REGIMEN IRREGULAR, AC The drug regimen reviewed at least licensed pharmacist in irregularities to the the director of num must be acted up Based on obse record review, ensure a time is [influenza vaccan open date in dementia unit. had the potential residents who in demential to recovaccine. Findings include On 10/15/12 at locked demential refrigerator was Licensed Pract At that time, 1 in Vaccine 5 millill open without at	I REVIEW, REPORT IT ON In of each resident must be once a month by a cist. Inust report any e attending physician, and rsing, and these reports on. Invation, interview, and the facility failed to sensitive medication ine] was labeled with in 1 of 1 locked This deficient practice all to affect 22 of 74 resided on the locked and who had the eive the influenza e: 12:30 P.M., tour of the is unit medication in initiated with ical Nurse [LPN] #1.	F04	TAG	F428 Drug Regimen Review, Report, Irregular, Act on It is the practice of the provide have each resident's drug regimen reviewed at least oncomonth by a licensed pharmacis. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The alleged deficient practice the potential to affect 22 reside on the secured Clare Bridge Dementia Unit. The opened violential to be affected by the same deficient practice will be identified and what corrective will be identified and what corrective.	r to e a st. had ents ial	
	· ·	#1 indicated she was ine needed an open			action(s) will be taken:		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			ĺ í
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155505	A. BUI	LDING	00	COMPLETED 10/18/2012
		155505	B. WIN			10/16/2012
NAME OF	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W	
ROBIN F	RUN HEALTH CENT	ER			APOLIS, IN 46268	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
IAG	date.	LSC IDENTIFYING INFORMATION)		TAG	The alleged deficient practice	DATE
	On 10/16/12 at Executive Dire	d Labeling" policy and			the potential to affect 22 reside on the secured Clare Bridge Dementia Unit. The opened vi of influenza vaccine was discarded.	ents
	but was not lim Medications ar labeled in accor requirements a	procedure included, nited to, "Policy: e packaged and ordance with facility and state and federal ure Small multidose			What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:	to
	vials, such as i drops, etc Th any appropriate precautionary a are placed on t prevent coverir	nsulin, eye drops, ear ne pharmacy label and e ancillary labels i.e. and date open stickers the packaging vial to			Licensed staff were re-educate on the facility's policy on storal labeling, and disposition/return drugs. The Pharmacist participates in the facility's Quantum Assurance Performance Improvement meetings which held monthly. Medication administration education is provided monthly by the Pharmacy, Director of Nursing designee.	ge, of ality are
					How the corrective action(s) will be monitored to ensure to deficient practice will not recise., what quality assurance program will be put into place. A Medication cart and refrigera Quality Assurance Performance Improvement audit tool will be completed daily times 1 month then 3 times per week until the alleged deficient practice does	ur, e: ator ce

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		A. BUILDING B. WING	COMPLETED 10/18/2012				
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W			
ROBIN R	UN HEALTH CENT	ER	INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505			(X2) MULTIPLE CO A. BUILDING	00	(X3) DATE SURVEY COMPLETED 10/18/2012
		10000	B. WING	ADDRESS, CITY, STATE, ZIP CODE	16/16/2012
NAME OF P	ROVIDER OR SUPPLIER			OBIN RUN W	
ROBIN R	UN HEALTH CENT	ER		IAPOLIS, IN 46268	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG F0441	REGULATORY OR 483.65	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
SS=D	SPREAD, LINEN The facility must of Infection Control of provide a safe, sa environment and development and and infection. (a) Infection Cont The facility must of Control Program (1) Investigates, of infections in the fac (2) Decides what isolation, should be resident; and (3) Maintains a resident	establish and maintain an Program designed to unitary and comfortable to help prevent the transmission of disease rol Program establish an Infection under which it - controls, and prevents acility; procedures, such as be applied to an individual			
	(b) Preventing Sp (1) When the Infe determines that a prevent the spreamust isolate the rule (2) The facility must a communicable elesions from direct their food, if direct disease. (3) The facility must their hands after elements.	ction Control Program resident needs isolation to d of infection, the facility esident. ust prohibit employees with disease or infected skin et contact with residents or t contact will transmit the ust require staff to wash each direct resident contact ashing is indicated by			
	Personnel must h	andle, store, process and o as to prevent the spread			
	Based on inter	view and record lity failed to ensure	F0441	F441 Infection Control, Preve Spread, Linens It is the pract	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		. NIII DDIG 00		COMPL	ETED
		155505		LDING		10/18/	
		10000	B. WIN	_		10/10/	
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					OBIN RUN W		
ROBIN R	UN HEALTH CEN	TER		INDIAN	IAPOLIS, IN 46268		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	that a chest X-Ray was completed at				of the provider to establish an	d	
	or within 6 mo	nths prior to admission;			maintain an Infection Control		
		alternative screening for			Program designed to provide		
		as done at admission,			safe, sanitary and comfortable		
		ent reviewed who was			environment and to help prevent	ent	
					the development and		
		"reactor" [having a			transmission of disease and infection. What corrective		
	positive reaction	on to the PPD-Purified			action(s) will be accomplished	od	
	Protein Deriva	tive skin test]; in a			for those residents found to		
	sample of 15 r	esidents. [Resident			have been affected by the		
	#49]	•			deficient practice: Resident	•	
]				#49 was admitted on 9/27/201		
	Findings includ	do.			The facility completed a	12.	
	Findings include	ie:			Tuberculosis screen and a ch	est	
					x-ray with negative results. H		
	In an interview	during the initial			other residents having the		
	orientation tou	r on 10/15/12 at 11:10			potential to be affected by th	ne	
	A.M., L.P.N. #	1 indicated Resident			same deficient practice will		
	#49 was admit				identified and what corrective		
		imer's unit about 1			action(s) will be taken: The		
					community will audit resident		
	_	he indicated the			medical records to verify that		
	resident was a	imbulatory.			residents have a current		
					Tuberculosis screen or chest		
	The clinical red	cord for Resident #49			x-ray if the resident has had a	Ī	
	was reviewed	on 10/18/12 at 10:15			positive PPD-Purified Protein		
	A M The resid	dent was admitted from			Derivative. What measures	will	
		on 9/27/12 with			be put into place or what		
	_				systemic changes will be ma	ade	
	_	t included, but were not			to ensure that the deficient		
	=	y body dementia,			practice does not recur:		
		sease, depression, and			Licensed staff was re-educa	ted	
	history of urina	ary tract infections.			on the admission process		
					requirement that residents ha	ve a	
	A chest X-Ray	report, dated 2/4/11,			Tuberculosis screen or chest		
	_	esident had no active			x-ray if the resident has had a	1	
					positive PPD-Purified Protein Derivative completed at or wit	hin	
		t time, with a calcified			6 months of admission. How		
	∣ granuloma in t	he left lung base.			corrective action(s) will be	ııı c	
					Corrective action(s) will be		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155505	B. WIN			10/18/	2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			6370 R	OBIN RUN W		
ROBIN R	RUN HEALTH CENT	ER			APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A "Record of Tests and				monitored to ensure the		
	Immunizations" form, sent from the previous facility and with dates of				deficient practice will not rec	ur,	
					i.e., what quality assurance		
	2010 and 2011	for flu vaccine,			program will be put into place	9 :	
		esident was a "reactor"			A Tuberculosis/chest x-ray Quality Assurance Performance	ے ا	
		[PPD] skin test.			Improvement audit tool will be		
	is the mantoux				completed by the Director of		
	A chest X-Ray	completed at or within			Medical Records or		
	·	to admission to Robin			designee weekly times1 quarte		
		ound. A tuberculosis			then monthly times 1 quarter u	ntil	
					the alleged deficient practice		
		eted at the time of			does not recur.		
	admission, was	s not found.					
	In an interview P.M., the intering indicated there miscommunical facility. She increquested an X assuming a curdone. They did on the report the 2/4/11. The interior Nursing indicate screen was not	on 10/18/12 at 4:20 m Director of Nursing					
	requested an X assuming a cui done. They did on the report the 2/4/11. The interior Nursing indicates screen was not at the time of a Run. 3.1-18(c) 3.1-18(g)	C-Ray report from them, rrent one had been do not realize the date nat was sent was for terim Director of the date a tuberculosis to done for this resident					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155505	B. WING		10/18/2012
	PROVIDER OR SUPPLIE		6370 F	ADDRESS, CITY, STATE, ZIP CODE ROBIN RUN W NAPOLIS, IN 46268	
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0514 SS=D	SSIBLE The facility must each resident in professional star are complete; ac readily accessibl organized. The clinical recomplete information to ide of the resident's care and service any preadmission the State; and properties and professional state; and professional s	nterview and record cility failed to have accurate a related to behavior attempted, for 1 of 8 ewed who were behaviors; in a sample s. [Residents #46] anterview and record cility failed to record the ician order for a diuretic at 1 resident acreased leg edema; in 5 residents. [Resident	F0514	F514 Resident Records-Complete/Accurate. cessible It is the practice of the provide maintain clinical records on earesident in accordance with acceptable professional standards and practices that a complete; accurately documented; readily accessib and systematically organized. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #46 Staff was re-educated on interventions. Resident care plan was updat and reviewed with staff regard resident specific interventions documenting in Care Tracker to	er to ach are le; I n ed ling

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155505	B. WIN			10/18/2012	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	₹					
DODIN D		TED.			OBIN RUN W		
ROBIN R	UN HEALTH CENT	IER		INDIAN	IAPOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	10/15/12 at 12	:50 P.M. Diagnoses			outcome of the intervention.		
		vere not limited to,					
		cular degeneration,			Resident #30 Licensed staff w	ere	
					re-educated on order		
	constipation ar	nd arthritis.			transcription, assessment,		
					documentation and notification	· .	
	The staff in the	e dementia unit track			Director of Nursing or designed	Э.	
	behaviors by d	ocumenting on the			Orders are reviewed daily by		
	_	vention Monthly Flow			Director of Nursing or designed	э.	
Record" documentation sheets. The directions on the flow sheet indicated, "Enter target behavior in one of the							
				How other residents having t			
				potential to be affected by the			
				same deficient practice will b			
Behavior Sections. Record the		ons. Record the			identified and what corrective)	
	number of epis	odes by shift with			action(s) will be taken:		
	initial. Enter the	e Intervention Code,			The Intendical linear Teams will		
		e and side effect codes			The Interdisciplinary Team will review residents exhibiting		
	with initial for e				behaviors weekly. In addition,		
	Witti II III tai 101 E	acii Siiit.			there will be a monthly meeting		
					review behaviors that were		
	The monthly flo	ow sheets for Resident			identified during the		
	#46 recorded y	elling episodes for the			Interdisciplinary Team weekly		
	following mont	hs:			review. Care Plans will be		
					updated as needed during the		
	May: 2 on 5/2	, 3 on 5/17, 3 on 5/22,			meetings and also resident		
	•				profiles in CareTracker will be		
	2 on 5/23, and				updated.		
		l, 2 on 6/9, 3 on 6/10, 3					
	on 6/12, 2 on	6/13, and 2 on 6/14.			Licensed staff were re-educate	ed	
	July: 4 on 7/4,	1 on 7/8, and 2 on			on order transcription,		
	7/16.				assessment, documentation a		
		he 4th, 3 on the 5th, 3			notification by Director of Nurs	ing	
		, 0 011 1.10 0111, 0			or designee. Orders are		
	on the 9th,	an 0/0 4 s = 0/5			reviewed daily by Director of		
<u>September</u> : 2 on 9/2, 1 on 9/5, and				Nursing or designee.			
	2 on 9/6.						
					What measures will be set in	to	
	All of these ent	tries indicated the			What measures will be put in	ان ا	
	behavior of vel	ling, but did not			place or what systemic changes will be made to		
	•	ervention, the outcome					
	mulcate the Int	ervention, the outcome			ensure that the deficient		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	LIA (X2) MULTIF		TIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED		
		155505	B. WING			10/18/2	2012	
NAME OF P	ROVIDER OR SUPPLIER	·			ADDRESS, CITY, STATE, ZIP CODE			
					OBIN RUN W			
ROBIN RUN HEALTH CENTER				INDIAN	APOLIS, IN 46268			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		-	TAG	DEFICIENCY)		DATE	
	code, or the side effects for each				practice does not recur:			
	shift.				Staff will be re-educated			
					regarding proper documentation	on,		
		with RN #13 on			interventions, outcomes and			
		0 P.M. she indicated			review of behavior flow sheet.			
		mark interventions			Licensed staff were re-educate	ed		
	_	e on the monthly			on order transcription,	cu		
	behavior flow r	ecord.			assessment, documentation a	nd		
					notification by Director of Nurs	sing		
					or designee. All orders are			
					reviewed daily by Director of Nursing or designee.			
					ivursing or designee.			
					How the corrective action(s)			
					will be monitored to ensure t			
					deficient practice will not rec i.e., what quality assurance	ur,		
					program will be put into place	e:		
					A Medication Administration			
					Record and Treatment			
					Administration Record Quality Assurance Performance			
					Improvement audit tool will be			
					completed daily times 4 weeks			
					then 3 times per week for one			
					quarter until the alleged deficie	ent		
					practice does not recur.			
					A Behaviors Quality Assuranc	e		
					Performance Improvement au			
					tool will be completed daily tim			
					4 weeks, then 3 times per week			
					for one quarter until the allege			
	R 1 The clinic	al record for Resident			deficient practice does not rec	ur.		
		ved on 10/16/12 at						
	mou was ieviev	ved on 10/10/12 at						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA (X2) N		2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION				A. BUILDING 00			COMPLETED	
		155505	B. WIN	G		10/18/	2012	
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	ROVIDER OR SUFFLIER			6370 R	OBIN RUN W			
ROBIN R	RUN HEALTH CENT	ER		INDIAN	APOLIS, IN 46268			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECT		ON (X5)		
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)			
	12:45 P.M.							
	but were not lir thrombocytope pressure, insor degeneration, of weakness. A comprehensisheet for teleph documented), if 1. Keflex 500 n (three times per days. 2. CBC of blood count) or	nia, high blood						
	interview with F dates that physical taken are experienced written/document comprehensive sheet in the de RN #1 did not F not documented date could affer give a medication of the confirmed received via telescause the Se indicated the fire							

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		IDENTIFICATION NUMBER: 155505	A. BUILDING B. WING	00	COMPLETED 10/18/2012
	PROVIDER OR SUPPLIER		6370 R	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	3.1-50(a)(1) 3.1-50(f)(4)				

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